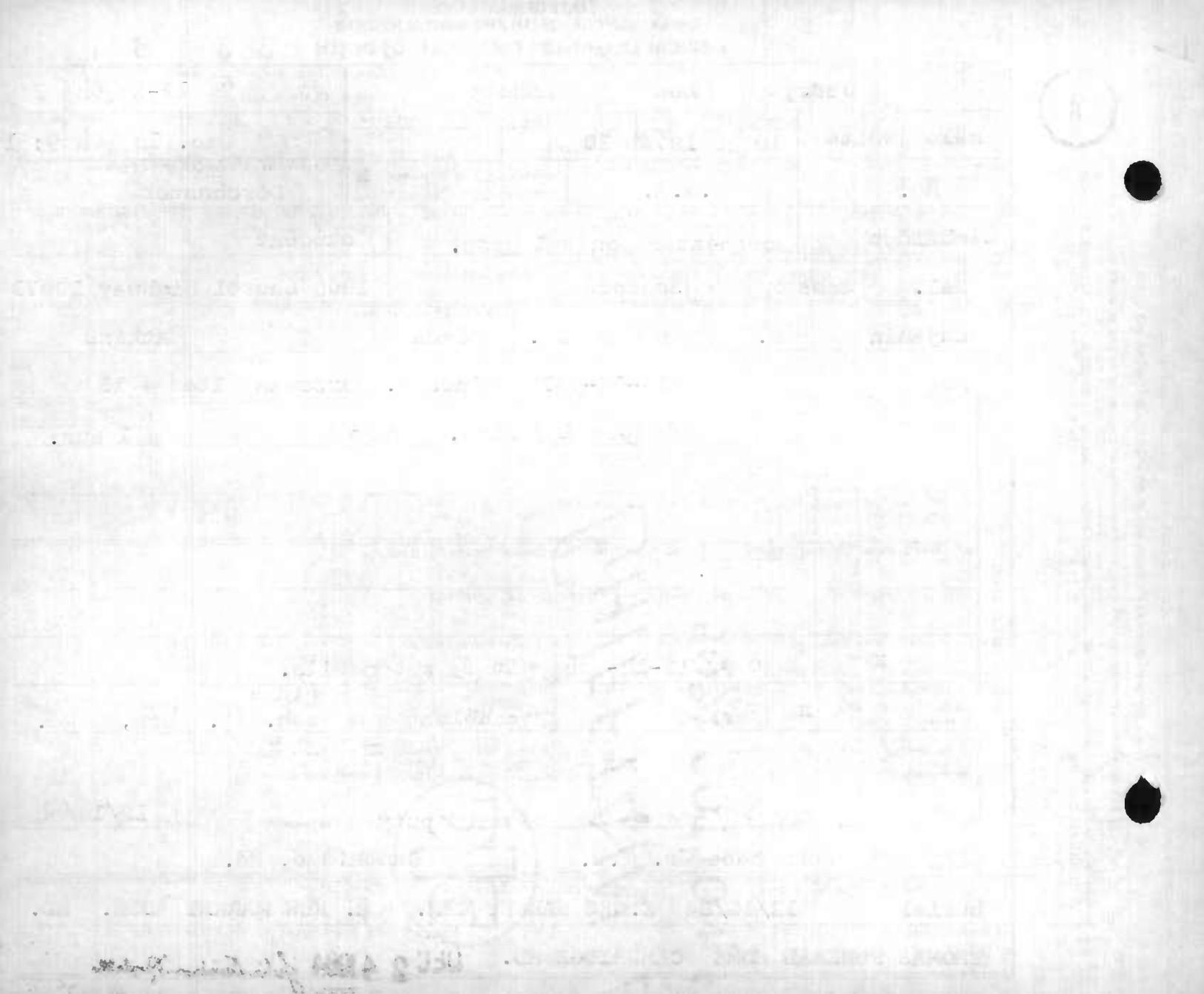


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3, RETAIN PAGE 4 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, AND 4 SHOULD BE FILED WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. 3.5 8 4 | | |
|---|--|---------|--|------------------------------------|--|---|--|-------------------------------|--|--------------------------------|---------------------------|--|--------|---|
| 1 - STATE REGISTRAR | | | 2a. DATE KNOWN OF ESTI- MATED DEATH | | | | | | | | | 2b. HOUR | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE | | | LAST | | | <input checked="" type="checkbox"/> MONTH 12-14, 1984 | | | YEAR 84 | P | |
| Jerry Lee Abbott | | | | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS) LAST BIRTHDAY | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR | | 2d. HOUR |
| male | | white | | 10 23 1974 | | 10 yrs. | | | | | | Dec. 14, 1984 | | 9:51 AM |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Md. | | | U.S.A. | | | | | | Dorchester | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Cambridge | | | Dorchester General Hosp. | | | | | | | | | student | | 99999 |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | MD. | |
| Del. | | | Sussex | | | Seaford | | | | | 1900 Laurel Highway 19973 | | | |
| 14. FATHER'S NAME FIRST | | | MIDDLE | | | LAST | | | 15. MOTHER'S MAIDEN NAME FIRST | | MIDDLE | | LAST | |
| Benjamin | | | H. | | | Abbott Jr. | | | Linda | | | | Atkins | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | | |
| No | | | 218-84-6432 | | | Linda A. Horseman | | | Item # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8147 IMMEDIATE CAUSE (a) <u>Multiple injuries, severe</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hur. | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9 PM. 12-14-1984 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Hit by automobile. | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street | | | 21f. LOCATION STREET Cambridge CITY OR TOWN Peachblossom & Wash. St. COUNTY Dor. STATE Md. | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John Mace Jr.</u> | | | TITLE (SPECIFY) M.D. Deputy, MEDICAL EXAMINER | | | | | | | | | DATE SIGNED 12/14/84 | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS Cambridge, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | | 23b. DATE 12/18/84 | | | 23c. NAME OF CEMETERY OR CREMATORIAL E. NEW MARKET CEM. | | | 23d. LOCATION CITY OR TOWN E. NEW MARKET COUNTY DOR. STATE MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME | | | ADDRESS CAMBRIDGE MD. | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR 12/18/84 | | 25b. REGISTRAR'S SIGNATURE <u>J. Mace Jr.</u> |
| VR A15 ME (5) 15M 7/77 | | | | | | | | | | | | | | |





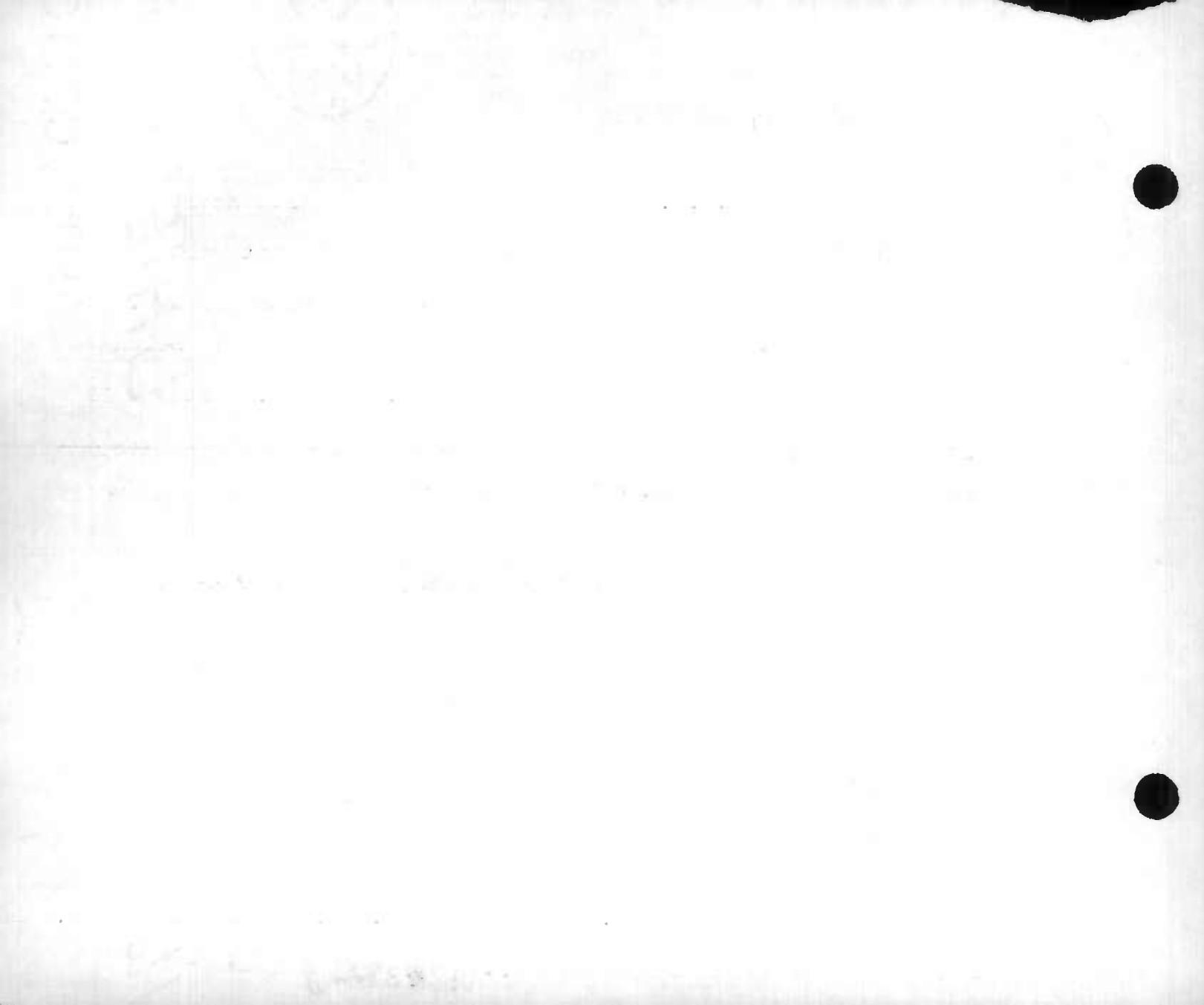
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the date with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

MEDICAL CERTIFICATION

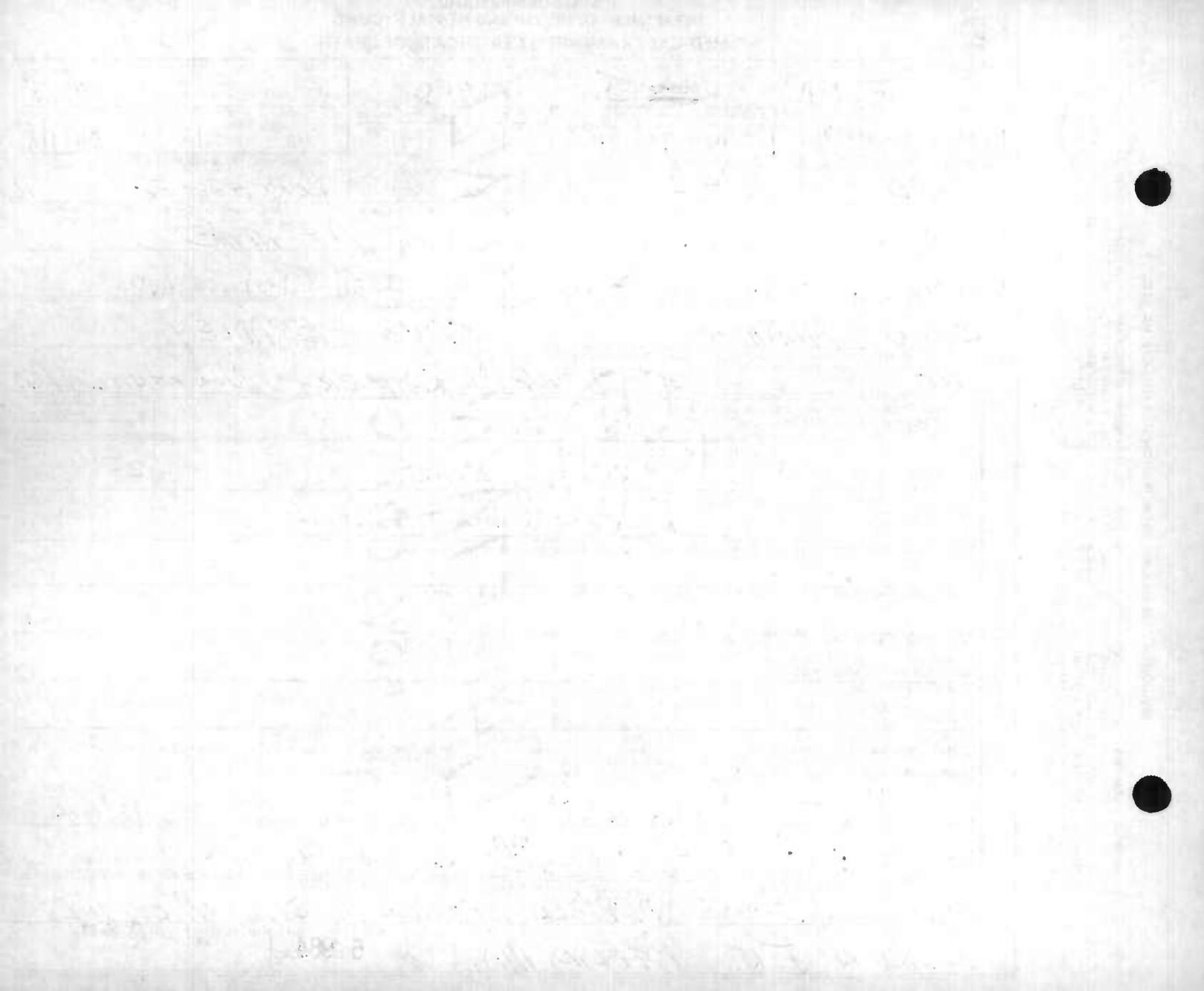
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 33586 | | | |
|--|--|--|---|-------------------|---|---|-----------|--------------------------------------|---|--|----------------|-------------------------------|------|
| | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | |
| <u>Dail</u> | | | <u>Lucy</u> | <u>R.</u> | | <u>12-7-84</u> | | | | | | <u>1059 A.M.</u> | |
| 3. SEX | | | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | # UNDER 24 HRS | | |
| <u>F</u> | | | <u>Cau.</u> | MONTH | DAY | YEAR | <u>87</u> | | | MONTHS | DAYS | HOURS | MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| <u>Md.</u> | | | <u>U.S.A.</u> | | | | | <u>Dorchester</u> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| <u>Cambridge</u> | | | <u>Dorchester General Hospital</u> | | <u>did not work</u> | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE | | | | |
| <u>Md.</u> | | | <u>Dorchester</u> | <u>Cambridge</u> | | | | | <u>202 Glenburns Ave. 21613</u> | | | | |
| 14. FATHER'S NAME | | | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | MIDDLE | | | LAST | | |
| <u>Henry</u> | | | <u>W.</u> | <u>Ruark</u> | <u>Lucy</u> | | | | | | <u>Leland</u> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | | | | |
| <u>No</u> | | | | | <u>Carroll L. Dail Jr.</u> | | | <u>Item # 13</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Just de-</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>As ID</u> | | | | | | | | | | <u>Years,</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Pneumonia, Organic Brain Syndrome</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | | | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) | | | 21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____ | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death. | | | | | | | | | | 22c. DATE SIGNED | | | |
| 22b. SIGNATURE <u>MD</u> DEGREE _____ ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | | | | |
| 22e. ADDRESS _____ | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____ | | | 23e. DATE REC'D. BY REGISTRAR | |
| <u>burial</u> | | | <u>12/10/84</u> | | | <u>E. NEW MARKET CEM.</u> | | | <u>E. NEW MARKET</u> | | | <u>REGISTRAR'S SIGNATURE</u> | |
| 24. FUNERAL DIRECTOR NAME <u>THOMAS FUNERAL HOME</u> ADDRESS <u>CAMBRIDGE MD.</u> | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 4 FOR FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 3 3 5 8 7 | |
|--|---------|--|--|----------------------------------|-----------------------------------|--|-------|---|---|--------------------------------------|--------|---|--------------------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH ESTIMATED | | | | MONTH | DAY | YEAR | 2b. HOUR 11A.M. |
| ELMA | | | | J. | DONOHO | <input type="checkbox"/> | | | | 12 | 1 | 1984 | 11A.M. |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YR. MONTHS DAYS | 8. IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD | | | | MONTH | DAY | YEAR | 2d. HOUR 11A.M. |
| FEMALE | WHITE | 9 14 93 | 91 YRS. | | | <input type="checkbox"/> | | | | 12 | 1 | 1984 | 11A.M. |
| 9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 10. CITIZEN OF WHAT COUNTRY? | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| MD | | USA | | | | <input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | | | | DORCHESTER | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| CAMBRIDGE | | DORCHESTER GENERAL HOSPITAL | | | | At Home | | | | | | | |
| 13a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. COUNTY | | 13d. CITY OR TOWN | | 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13f. STREET ADDRESS | | | |
| BALTIMORE | | Maryland | | Dorchester | | Cambridge | | <input checked="" type="checkbox"/> | | 311 Glenburn Ave 21613 | | | |
| 14. FATHER'S NAME | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | FIRST | MIDDLE | LAST | | | | |
| JOHN ADAMS | | | | | JANE BRADLEY | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | ADDRESS | | | | | |
| NO | | 212-09-7666 | | | | D. RAINIER - N. LINCOLN, MD | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. | | | | | | | | | | | | 25" | |
| { DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Arrest | | | | | | | | | | | | | |
| { DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart Failure | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | 20. AUTOPSY? | |
| n/a | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Hartmut A. Doerwaldt</u> (M.D.) | | | | | | | | | | | | TITLE (SPECIFY) | |
| EXAMINER'S NAME (TYPE OR PRINT) Hartmut A. Doerwaldt | | | | | | | | | | | | MEDICAL EXAMINER | |
| EXAMINER'S ADDRESS Dorchester General Hosp / Cambridge | | | DATE SIGNED 12/1/84 | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE 12-4-85 | | | 23c. NAME OF CEMETERY OR CREMATORIAL MARBELA MEMORIAL | | | 23d. LOCATION CITY/TOWN MARBELA, WIC., MD | | | COUNTY STATE | |
| BURIAL | | | 12-4-85 | | | MARBELA MEMORIAL | | | MARBELA, WIC., MD | | | | |
| 24. FUNERAL DIRECTOR NAME ULRICH F. H. | | | ADDRESS BERLIN, MD. | | | 25a. DATE REC'D. BY REGISTRAR DEC 6 1984 | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| 30M 7/73 | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 33588 REG. NO. | | | |
|---|--|---|---------------|--|---------------|---|---|--|---|-------------------|---|--|--|
| 1 - FOR STATE REGISTRAR | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | | | | 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST HELEN | | MIDDLE SPEEDDEN | LAST EVERHART | | | 12-11-84 | | 2:30 AM | | | |
| 3. SEX F | | 4. RACE CAUC. | | 5. DATE OF BIRTH MONTH 06 DAY 04 YEAR 04 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH CAMBRIDGE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY HOMEMAKING | | | | | | |
| 13a. STATE MD. | | 13b. COUNTY DORCHESTER | | 13c. CITY OR TOWN Cambridge | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE Rt. 3, Box 238 | | 13f. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Mo 13 | | |
| 14. FATHER'S NAME FIRST JAMES | | MIDDLE FRANKLIN | LAST SPEEDDEN | | | 15. MOTHER'S MAIDEN NAME FIRST FLORENCE | | MIDDLE ELIZABETH | LAST MARSHALL | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 214-07-8535 | | 17. INFORMANT husband | | | J. RUSSELL EVERHART, same as 13e | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | ACUTE MYOCARDIAL INFARCTION, PROBABLY TERMINATE | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | DUE TO, OR AS A CONSEQUENCE OF ALTEROSCLEROPIC HEART DISEASE 10+ YEARS | | | | | | | | | | | |
| (b) | | DUE TO, OR AS A CONSEQUENCE OF GENERALIZED ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 10+ YEARS | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. HYPERTHYROID STATE, POST OP HYDROAUGMENT AND Electrolyte imbalance with heart failure | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 11-1-84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED FRACTURE RT. HIP | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-28, 1984, to 12-11, 1984, that (I) (we) last saw the deceased alive on 12-11, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did <input type="checkbox"/> view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE DONALD R. McWILLIAMS | | 22c. DEGREE M.D. | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22e. DATE SIGNED 12-11-84 | | | | | | | |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD R. McWILLIAMS, M.D. | | 22g. ADDRESS 308 GAY STREET, CAMBRIDGE, MD 21613 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE 12/13/84 | | 23c. NAME OF CEMETERY OR CREMATORIAL Spedden-Seward Cen. | | 23d. LOCATION CITY OR TOWN Hudson, Dorchester, Md. | | COUNTY | | STATE | | | |
| 24. FUNERAL DIRECTOR NAME Curran Funeral Home | | ADDRESS 308 H ST. BR. Cambridge, Md. | | 25a. DATE REC'D. BY REGISTRAR DEC 13 1984 | | 25b. REGISTRAR'S SIGNATURE Gina Davidson-Randall | | | | | | | |

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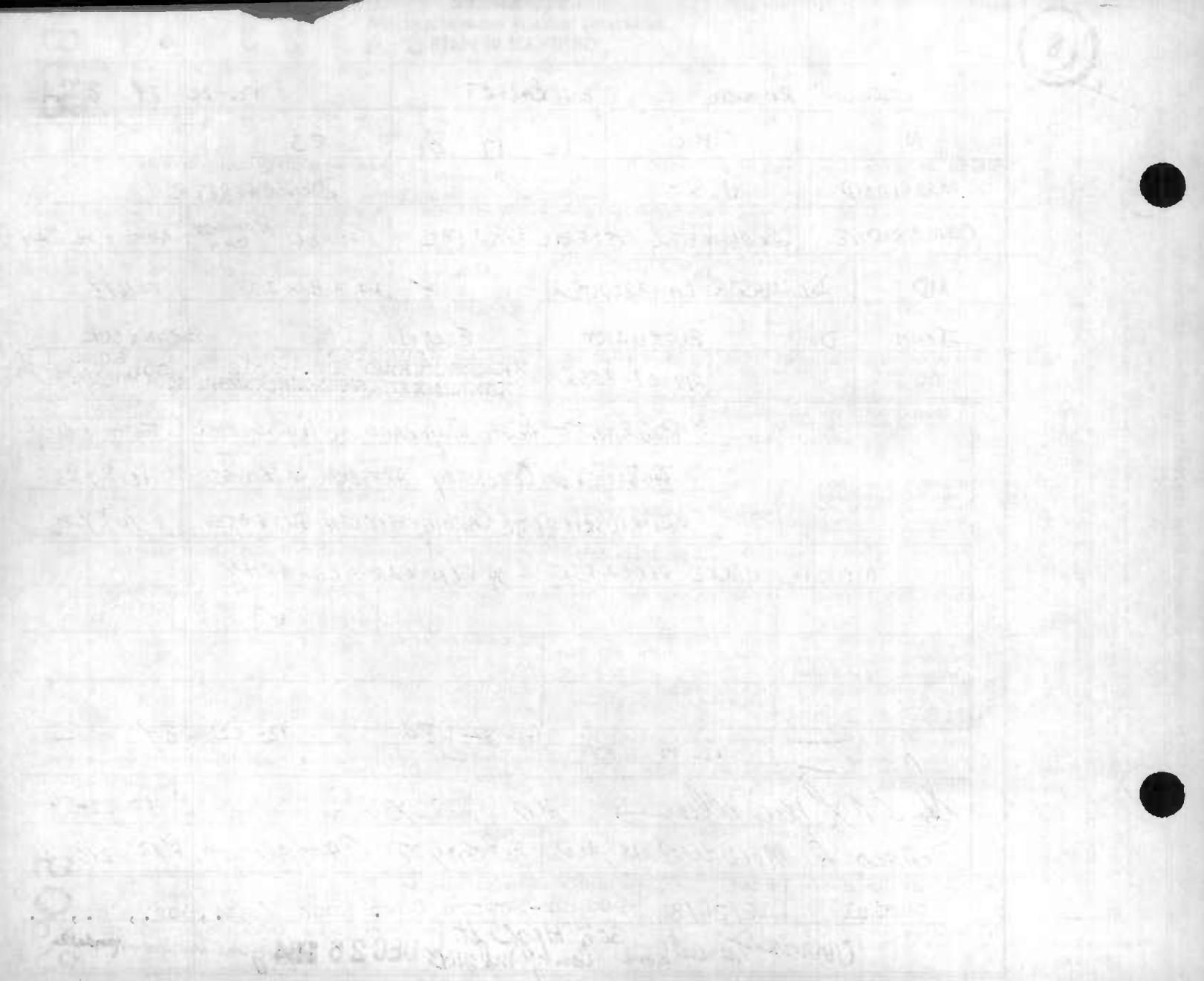
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner is to be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
|--|--|--|---|-------------------|----------|---|---|--------------------------|--|--------------------------------|-----------------|---|-------|-------|
| REG. NO. 33584 | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | | | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR 8 ⁴² -A.M. | | |
| John Russell | | | | | EVERHART | | | 12-22-84 | | | | | | |
| 3. SEX | | | 4. RACE | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | | IF UNDER 24 HRS | | | |
| M | | | Cauc | MONTH | DAY | YEAR | 83 | MONTHS | YEARS | | HOURS | MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| MARYLAND | | | U.S. | | | DORCHESTER | MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST WORKING TIME) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| CAMBRIDGE | | | DORCHESTER GENERAL HOSPITAL | | | Retired | | | NATIONAL CAN | | | | | |
| 13a. STATE | | | 13b. COUNTY | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE | | | | |
| MD | | | DORCHESTER | CAMBRIDGE | | | RT. 3 Box 238 | | | 21613 | | | | |
| 14. FATHER'S NAME | | | FIRST | MIDDLE | LAST | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| John D. | | | | | Ellen | | | LAST | | | BRANNOCK | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR ORDATES) | | | 17. INFORMANT | | | ADDRESS | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| NO | | | 214-07-8535 | | | X Daughter | | | Mrs. Doris Froson same | | | TERMINALLY | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | PROBABLY ACUTE Myocardial INFARCTION | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | DUE TO, OR AS A CONSEQUENCE OF (b) ADVANCED CORONARY ARTERY DISEASE | | | | | | 10+ yrs | | | | | |
| | | | DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | 10+ yrs | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY | STATE | |
| 22a. I certify that (1) <input type="checkbox"/> attended the deceased from saw the deceased alive on above (1) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death. | | | 12-17-1984 | | | 6-30-1980 | | | 12-22-1984 | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | | 12-22-84 | | |
| Donald R. McWilliams, M.D. | | | MS | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | | | | |
| Donald R. McWilliams, M.D. | | | 308 Gay St. Cambridge, MD 21613 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | | COUNTY | | STATE |
| burial | | | 12/24/84 | | | Spedden-Seward Cem. | | | Neck Dist., Dor. Co., Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Curran Funeral Home | | | 308 High St. Camb., Md. 21613 | | | DEC 26 1984 | | | Julia Dawson Pendleton | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be called before death can be certified.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | REG. NO. 33590 | | | | | | | |
|---|--|--|--------------------------|--|--|---|--|--|--|---------------------------------|---|----------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST <i>Franklin</i> | MIDDLE <i>BARRETT</i> | LAST <i>Ewell</i> | 2a. DATE OF DEATH MONTH DAY YEAR <i>12-9-84</i> | 2b. HOUR <i>1:05 PM</i> | | | | | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH 02 02 1909 | 6. AGE (IN YEARS LAST BIRTHDAY) 75 | IF UNDER 1 YEAR MONTHS YRS. | IF UNDER 24 HRS. HOURS MIN. 00 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester | | | | | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp. | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) crane operator | | 12b. KIND OF BUSINESS OR INDUSTRY MD. | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Dor. | | 13c. CITY OR TOWN Andrews | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE Rural 21626 | | | | |
| 14. FATHER'S NAME FIRST Charles | | MIDDLE Lyman | LAST Ewell | 15. MOTHER'S MAIDEN NAME FIRST Bertie | | MIDDLE | LAST Dayton | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2 | | 17. INFORMANT Jessie J. Ewell | | ADDRESS Box 159, Andrews Crapo Md. 21626 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic prostate cancer</i> | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | COUNTY | STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12-09</i> , 19 <i>84</i> , to <i>12-09</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>12-0-</i> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Christie L. Galvin MD</i> | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> | | MEDICAL DIRECTOR <input type="checkbox"/> | STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED <i>12-09-84</i> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Christie L. Galvin, MD</i> | | 22e. ADDRESS Dorchester General Hospital Cambridge, Md. 21613 | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE 12/12/84 | | 23c. NAME OF CEMETERY OR CREMATORIAL MARYLAND VETERANS | 24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME | ADDRESS CAMBRIDGE MD. | 25a. DATE REC'D. BY REGISTRAR <i>DEC 13 1984</i> | 25b. REGISTRAR'S SIGNATURE |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 minutes
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 33591 | | |
|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|
| 1 - FOR STATE REGISTRAR | | | 2a DATE OF DEATH 12 04 84 MONTH DAY YEAR | | | | | | | | | 2b HOUR 10 40 PM | | |
| 1. DECEASED NAME <small>TYPE OR PRINT</small> | | | MIDDLE THOMAS | | | LAST JEFFERINE EWELL | | | | | | | | |
| 3. SEX MALE | | | 4 RACE WHITE | | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 29 1894 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE STATE OR FOREIGN COUNTRY MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD. | | | | | |
| 10. CITY OR TOWN OF DEATH CAMBRIDGE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SERVICAL ENGINEER | | | 12b. KIND OF BUSINESS OR INDUSTRY ENGINEERING | | | | | |
| 13a. STATE MD. | | | 13b. COUNTY DORCHESTER | | | 13c. CITY OR TOWN CAMBRIDGE | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS ZIP CODE 102 HIGGINS ST. 21613 | | |
| 14. FATHER'S NAME FIRST THOMAS MIDDLE J. LAST EWELL | | | 15. MOTHER'S MAIDEN NAME FIRST MARY LAST ELIZABETH ROBINSON | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO. W 41 07 0039 | | | 17. INFORMANT MRS MARY EWELL SAME AS 13 | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | Cardiovascular arrest | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart failure | | | | | | | | | Years | | |
| | | | DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Heart Disease | | | | | | | | | Years | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 30, 1984, to Dec 4, 1984, that (I) (we) lost saw the deceased alive on Dec 4, 1984, and that (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE Edmund J. MacLaughlin | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 12/4/84 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edmund J. MacLaughlin | | | 22e. ADDRESS 10 Aurora St. Cambridge Md. 21613 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 12-8-84 | | | 23c. NAME OF CEMETERY OR CREMATORIAL OLD TRINITY CEM. | | | 23d. LOCATION CITY OR TOWN CHESAPEAKE, DORCHESTER, MD. COUNTY | | | | | |
| 24. FUNERAL DIRECTOR NAME CURRAN FUNERAL HOME | | | ADDRESS 21613 | | | 25a. DATE REC'D. BY REGISTRAR DEC 11 1984 | | | 25b. REGISTRAR'S SIGNATURE | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/statement permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked yes, any injury, or other traumatic event, the medical examiner must be notified even if item 18 shows no injury, or other traumatic event.

MEDICAL CERTIFICATION

| | | | | | | | | | | | |
|--|--|---|--------|--|--------------------------|--|--|---|--|------------------------------------|----------------|
| 1. DECEASED NAME [TYPE OR PRINT] | | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | MONTH | DAY | YEAR | 2b. HOUR |
| <i>Ikma Lynn L</i> | | | | <i>Woope</i> | | | <i>12 09 84</i> | | | | <i>5:15 PM</i> |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | |
| female | | white | | MONTH | DAY | YEAR | MONTHS | YEARS | MONTHS | YEARS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| N.Y. | | U.S.A. | | | | | Dorchester MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IE NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Cambridge | | Dorchester General Hosp. | | unknown | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Md. | | Dorchester | | Cambridge | | YES <input type="checkbox"/> | NO <input checked="" type="checkbox"/> | E.S.H.C. 21613 | | | |
| 14. FATHER'S NAME | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | ADDRESS | | LAST | | |
| | | Otto | | Fieanat | Naina | | | | Lindberg | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| No | | 578-28-4693 | | E.S.H.C. records | | 2 minutes | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Staphylococcus aureus Pneumonia</i> | | | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Organic Brain Syndrome</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> | NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> | NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>11-25-84</i> , 19 <i>84</i> , to <i>12-9</i> , 19 <i>84</i> , that <input checked="" type="checkbox"/> (we) lost sow the deceased alive on <i>12-9</i> , 19 <i>84</i> , and that in my <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we did) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Edmund J. MacLaughlin</i> | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> | | MEDICAL DIRECTOR <input type="checkbox"/> | | STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>12/9/84</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edmund J. MacLaughlin</i> | | 22e. ADDRESS <i>10 Aurora St. Cambridge Md 21613</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE <i>12/12/84</i> | | 23c. NAME OF CEMETERY OR CREMATORIUM <i>CAMBRIDGE CEM.</i> | | 23d. LOCATION CITY OR TOWN <i>CAMBRIDGE</i> | | COUNTY <i>DOR.</i> | | STATE <i>MD.</i> | |
| 24. FUNERAL DIRECTOR NAME <i>THOMAS FUNERAL HOME</i> | | ADDRESS <i>CAMBRIDGE MD.</i> | | 25a. DATE REC'D. BY REGISTRAR <i>DEC 13 1984</i> | | 25b. REGISTRAR'S SIGNATURE <i>J. L. Harter</i> | | | | | |

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2009-03-01 00:00:00-05:00

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR 1 - STATE REGISTRAR | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | 3 3 5 9 3 REG. NO. | | | |
|---|--|--|--|--|--|--|--|--|-----------------------------------|----------------------------|---------------------|--|--|
| I. DECEASED NAME (TYPE OR PRINT) | | FIRST BRICE | MIDDLE ASBURY | LAST HURLEY | 2a DATE OF DEATH 12/2/84 | | | MONTH YEAR | DAY | 2b. HOUR 15 A.M. | | | |
| 3. SEX male | | 4 RACE white | S. DATE OF BIRTH 01 22 1900 | 6. AGE (IN YEARS LAST BIRTHDAY) 84 | | | IF UNDER 1 YEAR MONTHS 84 YRS | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp. | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) waterman | | | 12b KIND OF BUSINESS OR INDUSTRY self emp. | | | | | |
| 13a STATE Md. | | 13b COUNTY Dor. | 13c CITY OR TOWN Elliott | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 14 STREET ADDRESS Elliott Island 21869 | | | | | | | |
| 14. FATHER'S NAME FIRST McClain | | MIDDLE W. | LAST Hurley | 15. MOTHER'S MAIDEN NAME FIRST Olevea | | MIDDLE | LAST Dayton | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. 213-18-5994 | | 17 INFORMANT Elma E. Hurley | | ADDRESS Elliott Md. 21869 | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | DUE TO, OR AS A CONSEQUENCE OF Cerebrovascular Accident | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | b) Hypertension | | | 10 yrs | | | | | | | | |
| | | c) Diabetes Mellitus | | | 10 yrs | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | |
| 22a I certify that (I) (this hospital) attended the deceased from 11/20/84 , 19_____, to 12/2/84 , 19_____, that (I) (we) last saw the deceased alive on 12/1/84 , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b SIGNATURE Lorraine Mayauer | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 12/2/84 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e ADDRESS | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE 12/5/84 | | 23c NAME OF CEMETERY OR CREMATORIAL ELLIOTT CHURCHYARD | | | 23d. LOCATION CITY OR TOWN ELLIOTT | | COUNTY DOR. | | STATE MD. | | |
| 24 FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME | | ADDRESS CAMBRIDGE MD. | | | 25. DECEASED BY MEDICAL EXAMINER'S SIGNATURE Jane Landon Pendall | | | | | | | | |

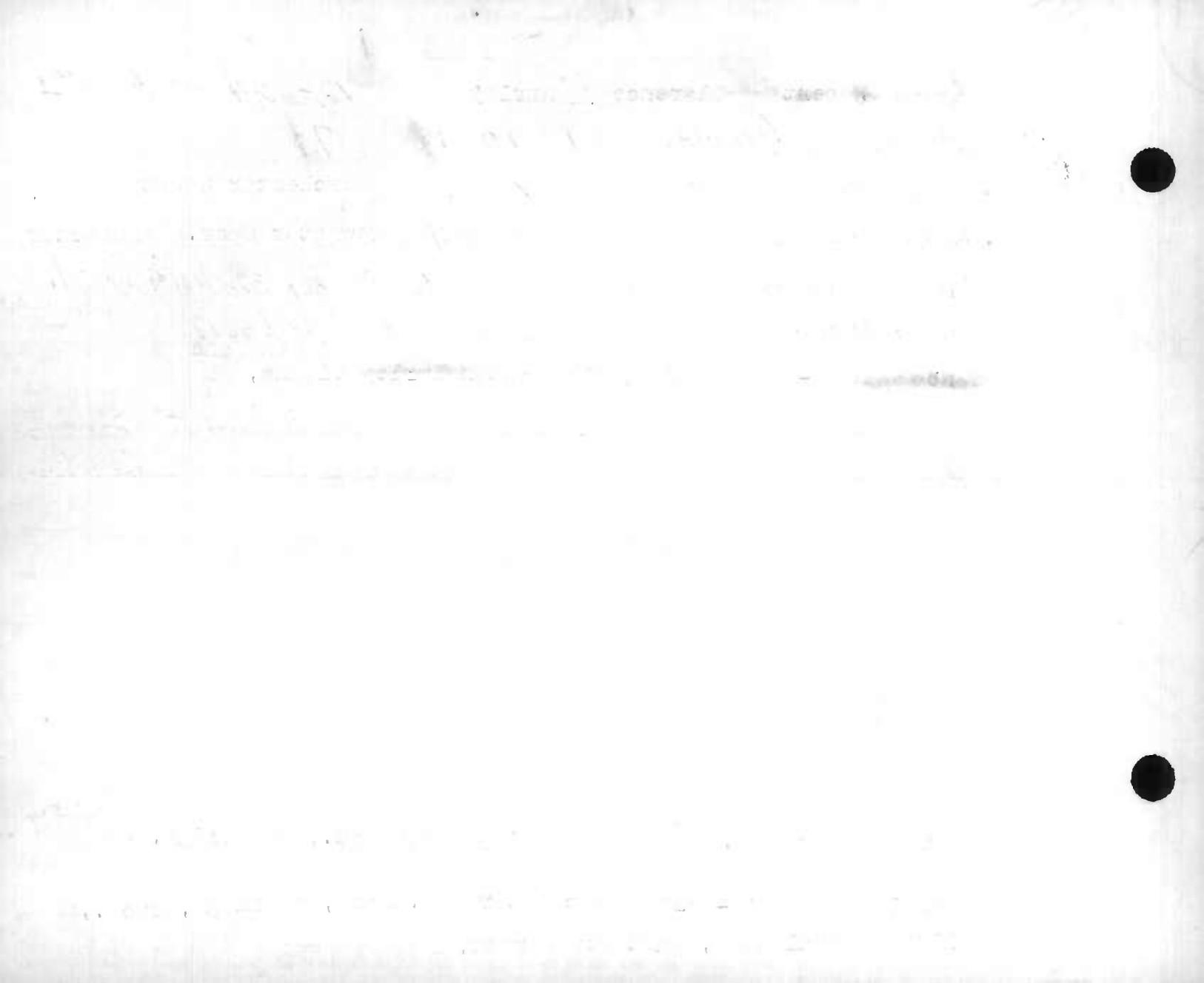
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 33594 | | |
|---|--|--|---|--|--|--|--|--|--|--|--|---|--|--|
| 1 - FOR STATE REGISTRAR | | | 2a. DATE OF DEATH 12-24-84 MONTH DAY YEAR | | | | | | | | | 2b. HOUR 10:30 A.M. | | |
| 1. DECEDENT'S NAME (TYPE OR PRINT) Robert Clarence Hurley | | | MIDDLE | | | LAST | | | | | | | | |
| 3. SEX MALE | | | 4. RACE Caucasian | | | 5. DATE OF BIRTH MONTH 1 DAY 10 YEAR 14 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Dor. Co. Md. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Towmotor Oper. | | | 12b. KIND OF BUSINESS OR INDUSTRY Manufactur | | | | | |
| 13a. STATE Md. | | | 13b. COUNTY Dorchester/Cambridge | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE P.O. BOX 132 - Holloman St. 21869 | | | | | |
| 14. FATHER'S NAME Alford Hurley | | | 15. MOTHER'S MAIDEN NAME Etta M. Richardson | | | 17. INFORMANT Linda Moore Lane | | | 18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No | | | 16b. SOCIAL SECURITY NO. 318-16-9340 | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterial Myo and dil. of aorta</i> | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterial Myo and dil. of aorta</i> | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | DUE TO, OR AS A CONSEQUENCE OF (b) | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | DUE TO, OR AS A CONSEQUENCE OF (d) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | 22c. DATE SIGNED 12/24/84 | | |
| 22b. SIGNATURE <i>Leanne</i> | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mahmood Sheriff, MD | | | 22e. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22f. ADDRESS 105 Aurora St., Cambridge, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 12-27-84 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park, Cambridge, Dorch., MD | | | 23d. LOCATION CITY OR TOWN Cambridge, Dorch., MD | | | COUNTY STATE | | |
| 24. FUNERAL DIRECTOR Zelter Funeral Home, East New Market, MD | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 3 1985 | | | 25b. REGISTRAR'S SIGNATURE <i>Lillian Davidson-Pendall</i> | | | | | |
| DHMH - 16 50M 4/83 (VRA 15, 4) | | | | | | | | | | | | | | |

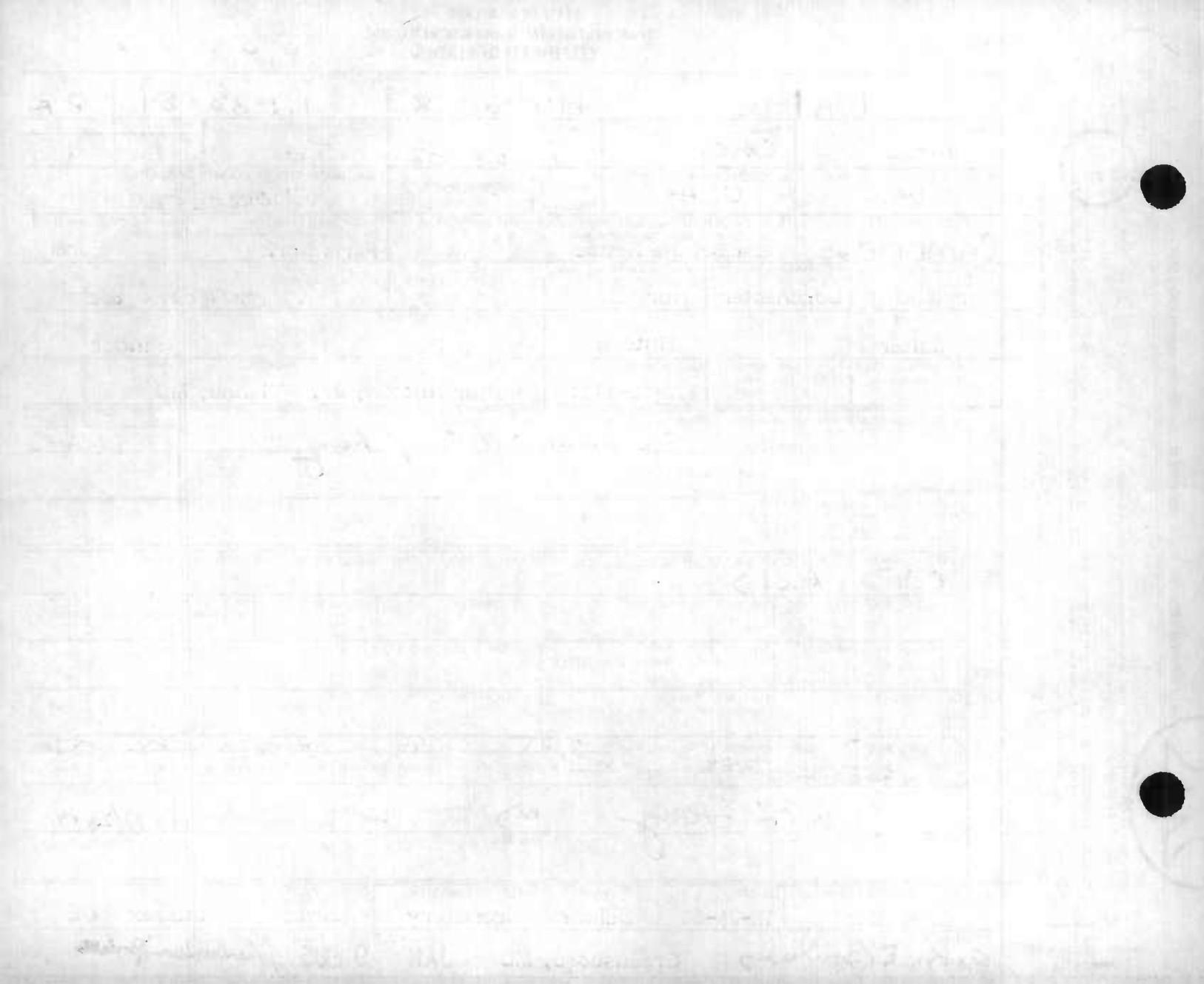


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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 33595 | |
|--|--|--|--|--|--|---|--|--|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR 12-28-84 | | | | | | | | | 2b. HOUR 8 AM | |
| 1. DECEASED NAME (TYPE OR PRINT) Walter | | | MIDDLE | | | LAST Hutson Sr. | | | | | | | |
| 3. SEX MALE | | | 4. RACE CAUC | | | 5. DATE OF BIRTH MONTH DAY YEAR 1 27 08 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD. | | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farm Work | | | 12b. KIND OF BUSINESS OR INDUSTRY Farm | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Dorchester | | | 13c. CITY OR TOWN Hurlock | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS GLENBURN AVE 21643 | |
| 14. FATHER'S NAME FIRST Walter | | | MIDDLE | | | LAST Hutson | | | 15. MOTHER'S MAIDEN NAME Della | | | LAST Pinder | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 218-12-1721 | | | 17. INFORMANT Walter Hutson, Jr. | | | ADDRESS Vienna, MD | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell Ca of lung | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 29 months | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | | | | | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: COPD, ASCVD | | | | | | | | | | | | | |
| 19a. MEDICAL CERTIFICATION DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | COUNTY | STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/25/84 to 12/28/84, saw the deceased alive on 12/28/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | | 22c. DATE SIGNED 12/28/84 | |
| 22b. SIGNATURE Hubert G. Frey | | | DEGREE MD | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hubert G. Frey | | | 22e. ADDRESS | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 12-28-84 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory | | | 23d. LOCATION CITY OR TOWN Lewes | | COUNTY Sussex | STATE DE | |
| 24. FUNERAL DIRECTOR John E. Bowden | | | ADDRESS Greensboro, MD | | | 25a. DATE REC'D. BY REGISTRAR JAN 9 1985 | | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Bowden | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | 33 5/9 6 | | | | |
|---|--|--|---|--|--|--|--|--|---|--|--|---|-------|------|-----------------|--|
| | | | | | | | | | | | | REG. NO. | | | | |
| 1. FOR STATE REGISTRAR | | | FREDERICK D. | | | JACKSON | | | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR | |
| I DECEASED NAME (TYPE OR PRINT) | | | FIRST | | | MIDDLE | | | LAST | | | 12 5 84 | | | 11 40 AM | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS | |
| Male | | | Black | | | MONTH DAY YEAR | | | 53 | | | MONTHS DAYS | | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | | |
| Md. | | | Dorchester | | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | Dorchester County | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Cambridge | | | Dorchester General Hospital | | | Laborer | | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE | | | | |
| Md. | | | Dorchester | | | Cambridge | | | | | | Browns St 21613 | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 17. INFORMANT | | | ADDRESS | | | | |
| Frederick | | | Jackson Jr. | | | 16b. SOCIAL SECURITY NO. | | | Betty Jackson | | | 711 Rigby Ave Md. | | | | |
| | | | Mable | | | 213-24-1508 | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CACHEXIA + DEHYDRATION</u> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | 1b) <u>ADENOCARCINOMA, METASTATIC TO LUNGS, LIVER</u> | | | DUE TO, OR AS A CONSEQUENCE OF | | | YEAR | | | | | | | |
| | | | 1c) <u>ADENOCARCINOMA OF RECTOSIGMOID</u> | | | | | | | | | YEARS | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>DIABETES, SEVERE PERIPHERAL VASCULAR DISEASE, BILATERAL BK AMPUTATIONS</u> | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION <u>5-6-83</u> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>COLESTOMY FOR INOPERABLE CARCINOMA OF RECTOSIGMOID</u> | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY | STATE | | | |
| 22a. I certify that (I) this hospital) attended the deceased from <u>5-6-83</u> to <u>12-5-84</u> , that (I) we last saw the deceased alive on <u>12-5-84</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We did/did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>JAMES F. McCARTER</u> | | | DEGREE MD. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED <u>12-5-84</u> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAMES F. McCARTER</u> | | | 22e. ADDRESS <u>400 AURORA ST. CAMBRIDGE, MD. 21613</u> | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | 23b. DATE <u>Dec. 8, 1984</u> | | | 23c. NAME OF CEMETERY OR CREMATORIAL <u>Waugh Cemetery</u> | | | 23d. LOCATION CITY OR TOWN <u>Cambridge Dorchester Md.</u> | | | COUNTY | STATE | | | |
| 24. FUNERAL DIRECTOR NAME <u>Stewart Funeral Home</u> | | | ADDRESS <u>Salisbury, MD.</u> | | | 25a. DATE REC'D. BY REGISTRAR <u>DEC 11 1984</u> | | | 25b. REGISTRAR'S SIGNATURE <u>Wendell</u> | | | | | | | |

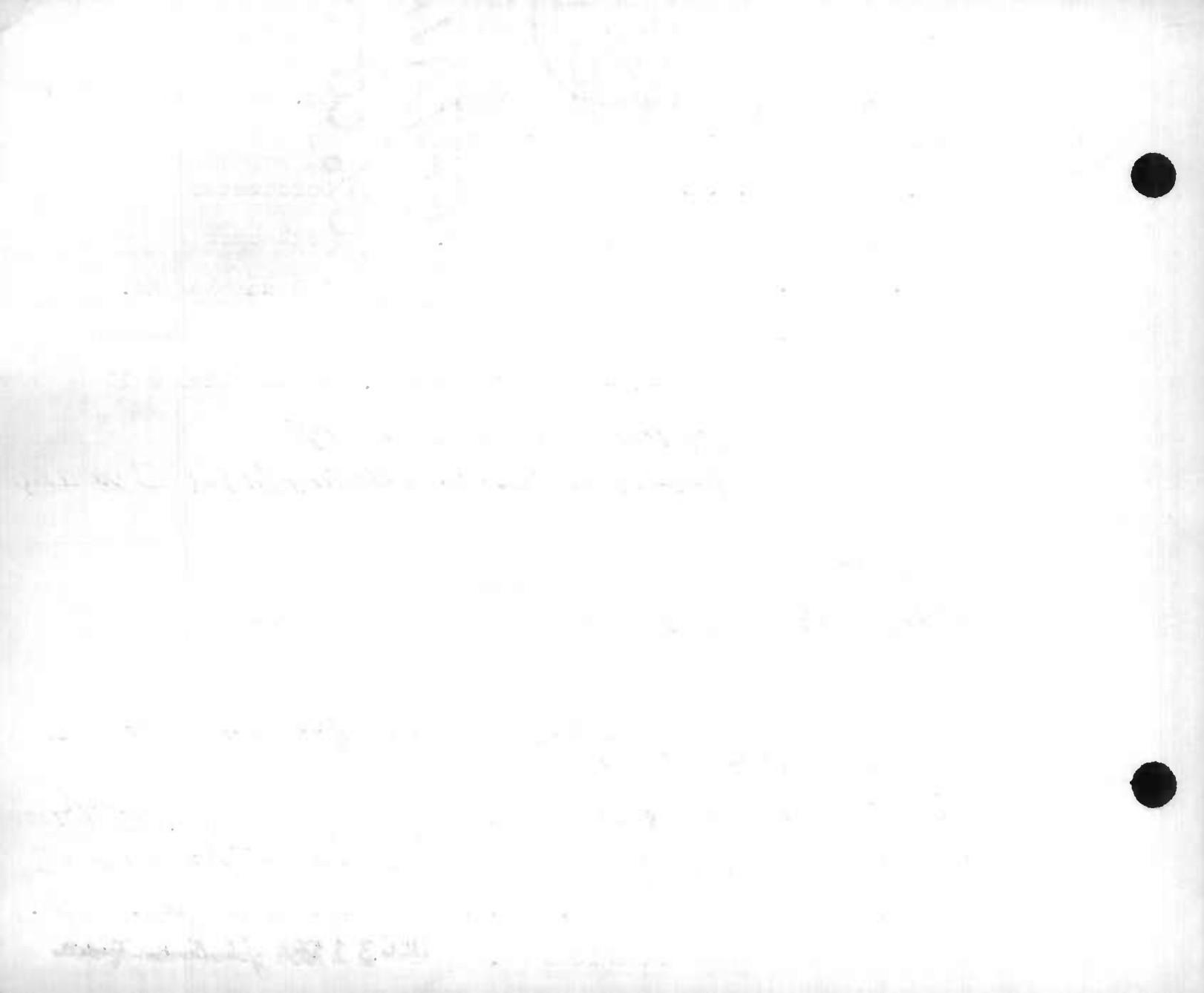


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 33597 | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|
| 1 - FOR STATE REGISTRAR | | | 2a. DATE OF DEATH Dec. 24 1984 | | | | | | | | | 2b. HOUR 5 p m | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Dorothy Mae Latham | | | MIDDLE | | | LAST | | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | | |
| 3. SEX female | | | 4. RACE white | | | 5. DATE OF BIRTH MONTH 05 DAY 11 YEAR 1908 | | | 6. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | | 9. CITY OR TOWN OF DEATH Cambridge | | | 10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp. | | | 11. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md. COUNTY Dor. CITY OR TOWN Cambridge | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) bookkeeper | | | 12b. KIND OF BUSINESS OR INDUSTRY M.D. | |
| 13. FATHER'S NAME FIRST Charlie MIDDLE F. LAST Wroten | | | 14. MOTHER'S MAIDEN NAME FIRST Henrietta MIDDLE | | | 15. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 16. SOCIAL SECURITY NO. 217-36-2106 | | | 17. INFORMANT Clarence W. Latham | | | 18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21613 | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No | | | 18b. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of rectum with metastases 3 years | | | 18c. DUE TO, OR AS A CONSEQUENCE OF (b) 3 years | | | 18d. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| 19. MEDICAL CERTIFICATION PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION May 1982 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Above | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) May | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 24 1984 to Dec 24 1984, that (I) (we) last saw the deceased alive on Dec 24 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Lewis M. Burdette MD | | | 22c. DEGREE | | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22e. ADDRESS 4 Harpers Cambridge Md 21613 | | | 22f. DATE SIGNED 12/24/84 | | | | |
| 22g. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis M. Burdette | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | | 23b. DATE 12/27/84 | | | 23c. NAME OF CEMETERY OR CREMATOR Y Dor. Mem. Park | | | 23d. LOCATION CITY OR TOWN Cambridge COUNTY Dor. STATE Md. | | | | |
| 24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME | | | ADDRESS CAMBRIDGE MD. | | | 25a. DATE REC'D. BY REGISTRAR DEC 31 1984 | | | 25b. REGISTRAR'S SIGNATURE Julian Johnson | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for us as the burial-trust permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be called at once.

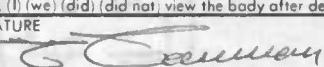
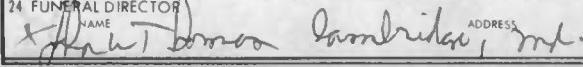
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 33598 | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|-------------------------------|--|--|--|
| 1 - FOR STATE REGISTRAR | | | 2a DATE OF DEATH MONTH DAY YEAR Dec 24, 1984 | | | | | | | | | 2b HOUR 7:30pm | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST George P Lippincott | | | 5. DATE OF BIRTH MONTH 06 DAY 23 YEAR 1905 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | | |
| 3. SEX male | | | 4. RACE white | | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.J. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) executive-manufacturing | | | 12b. KIND OF BUSINESS OR INDUSTRY MD. | | | | | | | | |
| 13a. STATE Md. | | | 13b. COUNTY Dor. | | | 13c. CITY OR TOWN Cambridge | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 102 Shawnee Circle 21613 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George P. Lippincott | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Narcissa Masters | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 208-03-6491 | | | 17. INFORMANT Rosalie H. Lippincott | | | ADDRESS Item 13 | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | DUE TO, OR AS A CONSEQUENCE OF (b) <u>Colon with metastases</u> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION Nov 1984 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Above</u> | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>Dec 24 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (do) not view the body after death. | | | 22b. DEGREE Lewis M. Burlette MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 12/24/84 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis M. Burlette | | | 22e. ADDRESS 4 Aurora St Cambridge MD 21613 | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation | | | 23b. DATE 12/26/84 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory | | | 23d. LOCATION Lewes Sussex Delaware | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE MD. | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR DEC 3 1984 | | | 25b. REGISTRAR'S SIGNATURE John Davidson Burlette i | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner may be notified of such.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 33594 | |
|---|--|--|-------------------|---|---|----------------------------------|---|--|--|--|-------------------------------|------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | | |
| Horace O. Moore | | | | | | 12 23 84 | | | 6 A.M. | | | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH 08 DAY 04 YEAR 1908 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS Cambridge House | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) did not work | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Dor. | | 13c. CITY OR TOWN Cambridge | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 520 Glenburn Ave. 21613 | | | | |
| 14. FATHER'S NAME FIRST Christopher C. MIDDLE Moore LAST | | 15. MOTHER'S MAIDEN NAME FIRST Ida MIDDLE E. LAST Bloodsworth | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 218-76-1976 | | 17. INFORMANT Odus Moore | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF Dwarfism. | | ADDRESS Rt 3 Box 289 A Cambridge Md | | | | |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | 22c. DATE SIGNED 12-23-84 | |
| 22b. SIGNATURE  | | 22c. DEGREE MD | | | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> | | 22e. MEDICAL DIRECTOR <input type="checkbox"/> | | 22f. STAFF PHYSICIAN <input type="checkbox"/> | | | | |
| 22g. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22h. ADDRESS | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE 12/26/84 | | 23c. NAME OF CEMETERY OR CREMATORIAL Dor. Memorial Park | | | 23d. LOCATION CITY OR TOWN Cambridge COUNTY Dor. STATE Md. | | | | | | |
| 24. FUNERAL DIRECTOR NAME  | | 25a. DATE REC'D. BY REGISTRAR DFC 28 1984 | | | 25b. REGISTRAR'S SIGNATURE Julie K. Kivinen, R.P.T. | | | | | | | | |



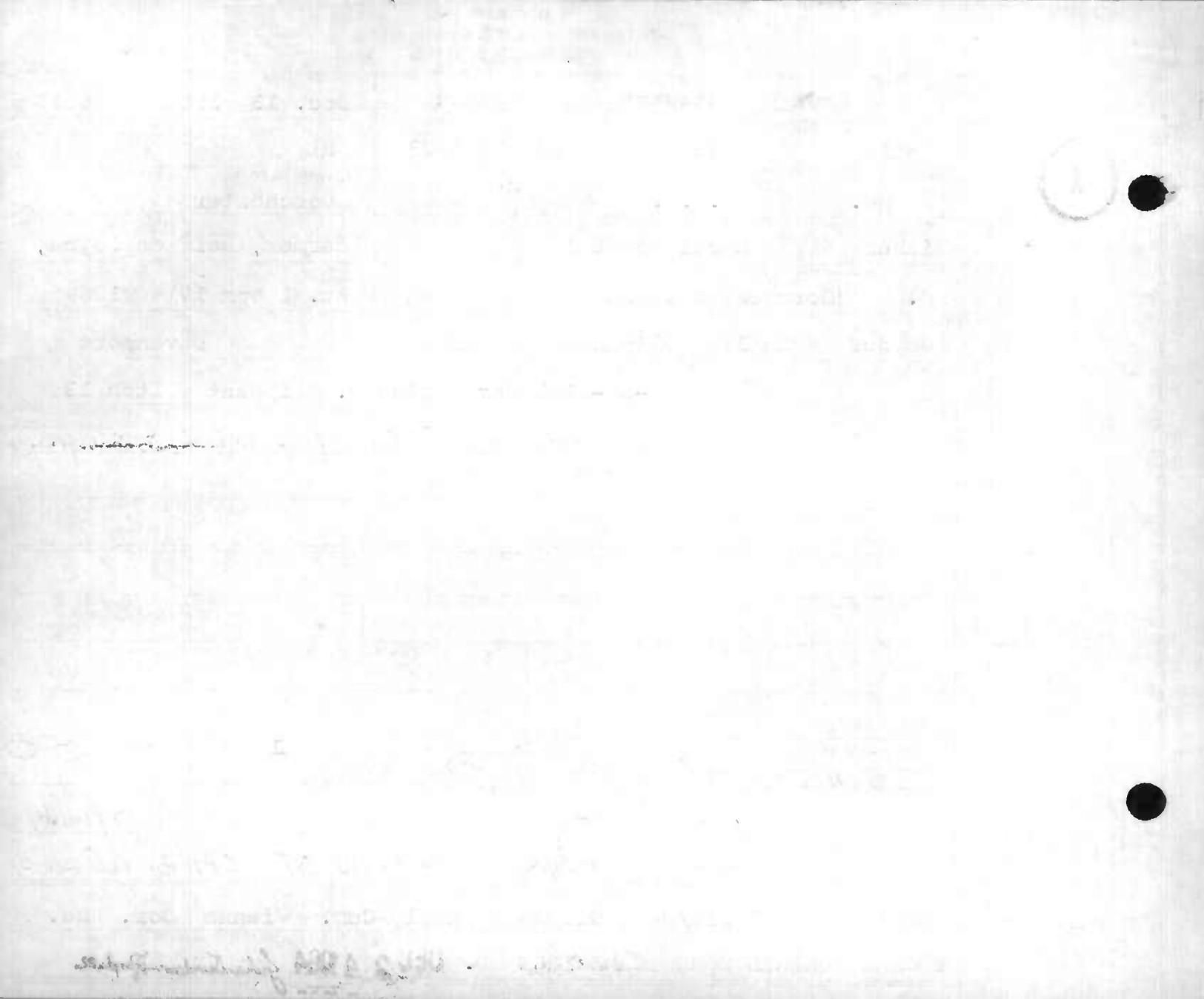
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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after the death or removal by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the physician, it should be forwarded for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 33600 | | | |
|---|--|--|--|--|--|---|--|---------------|--|--|--------------------------------|--|--|---------------------------------|--|
| 1 - STATE REGISTRAR | | | 2a. DATE OF DEATH Dec. 13 1984 | | | | | | | | | 2b. HOUR 0515 M | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST Leon | | | MIDDLE Stewart | | LAST Oliphant | | | 2a. DATE OF DEATH Dec. 13 1984 | | | 2b. HOUR 0515 M | |
| 3. SEX male | | | 4. RACE white | | | 5. DATE OF BIRTH 04 12 1903 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 | | | IF UNDER 1 YEAR MONTHS | | IF UNDER 24 HRS DAYS HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH Vienna | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rural route 1 | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) farmer, self employed, | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| 13a. STATE Md. | | | 13b. COUNTY Dorchester | | | 13c. CITY OR TOWN Vienna | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS Rt. 1 Box 171 21869 | | | |
| 14. FATHER'S NAME FIRST Geyser MIDDLE Franklin LAST Oliphant | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Ella MIDDLE Davenport LAST | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 215-36-2143 | | | 17. INFORMANT Marguerite B. Oliphant | | | ADDRESS Item 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Adeno Ca of Sigmoid | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~1 year | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. 12 P.M. MONTH Dec. DAY 19 YEAR 84 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 5128 | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/9/84 to 12/13/84, saw the deceased alive on 12/9/84, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | | | 22c. DATE SIGNED 12/14/84 | | | |
| 22b. SIGNATURE Hubert L. Frey | | | | | | DEGREE | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hubert L. Frey | | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | | 23b. DATE 12/15/84 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Oliphant Family Cem. | | | 23d. LOCATION CITY OR TOWN Vienna COUNTY Dor. STATE Md. | | | | | | |
| 24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME | | | ADDRESS CAMBRIDGE MD. UEL 24 1984 | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| BP _____ | | | | | | | | | | | | | | | |
| DHMH - 16 60M 1/75 (VRA 15 (4)) | | | | | | | | | | | | | | | |



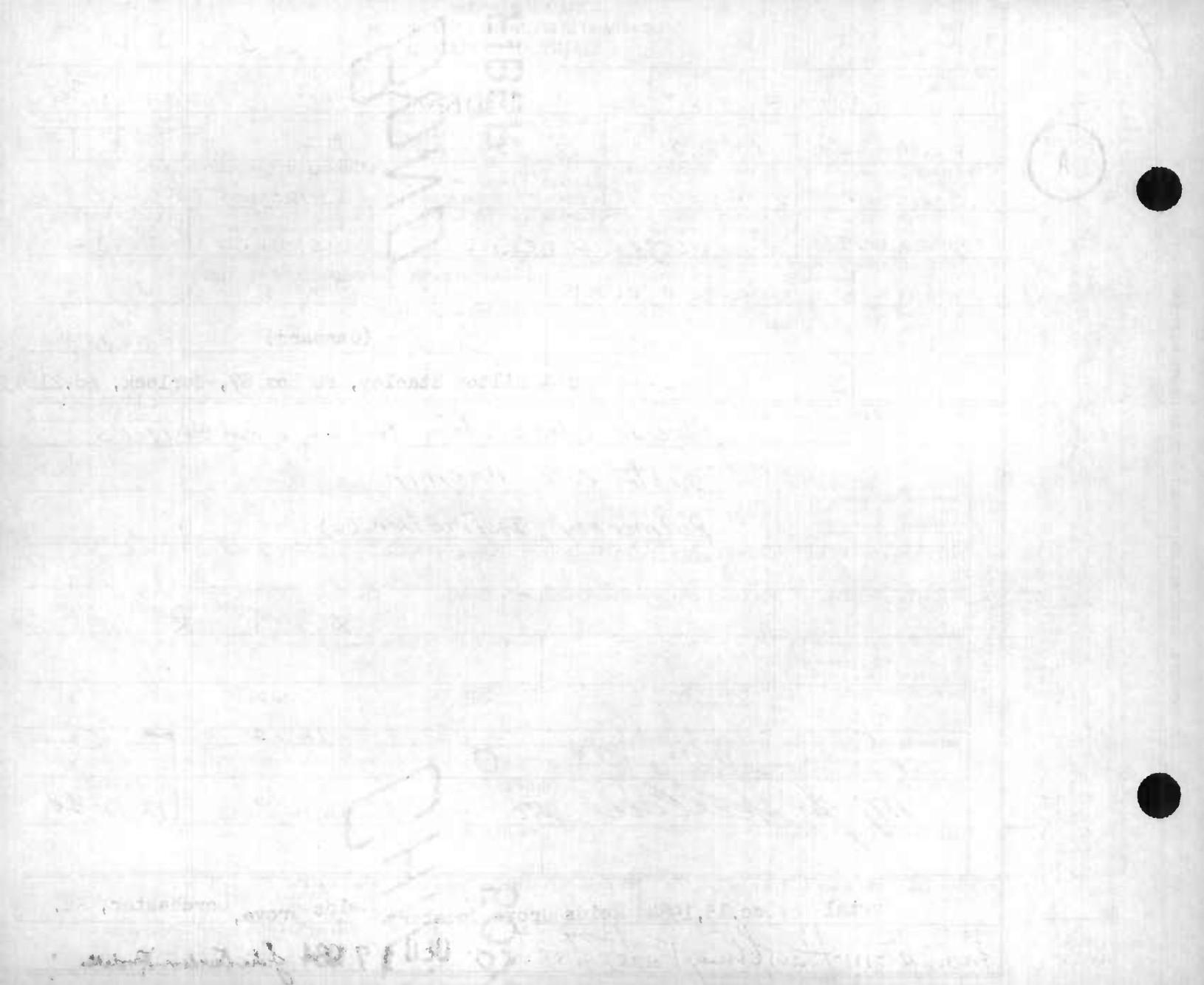
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3) should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

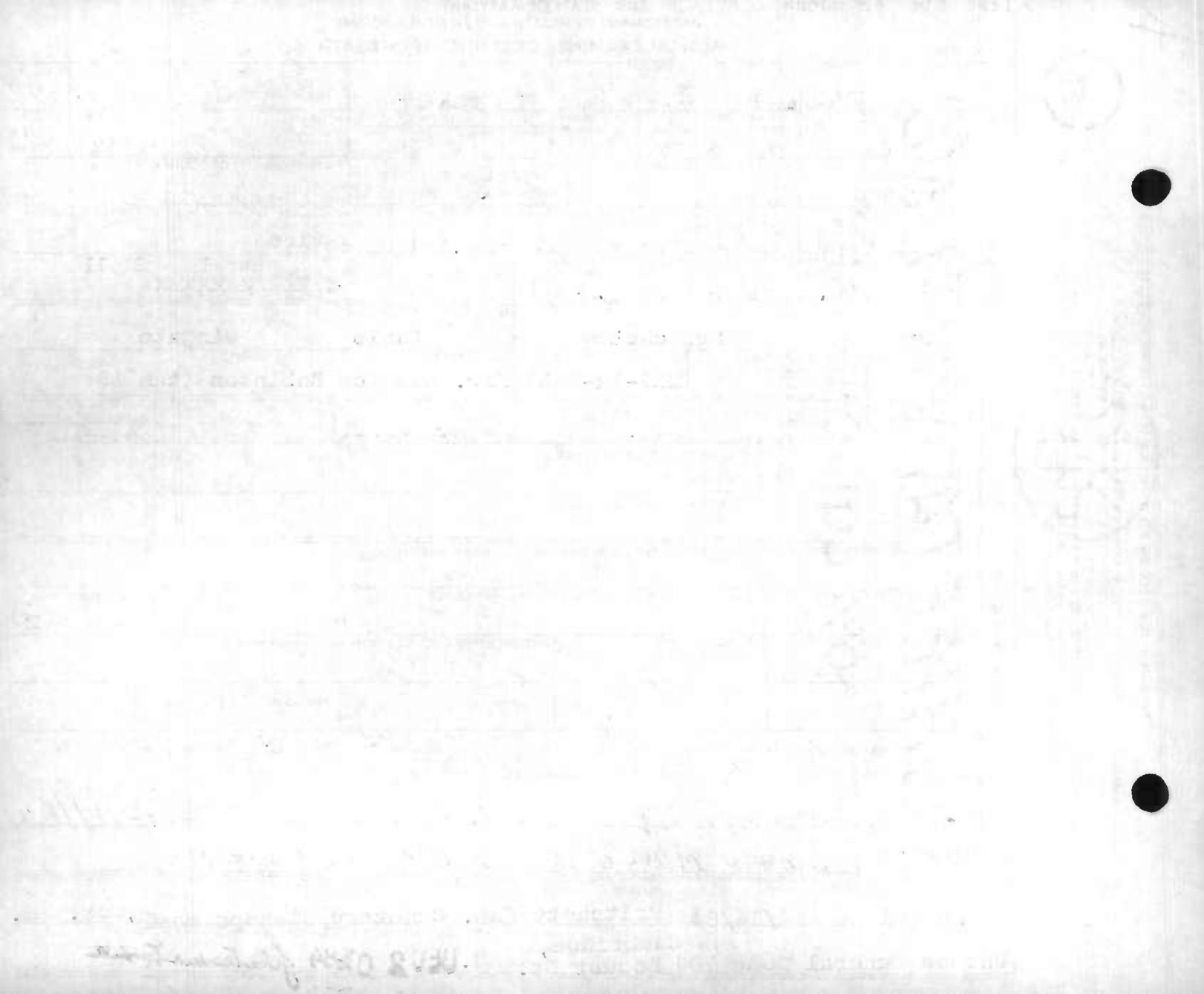
MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 33601 | |
|--|--|------------------------------|---|---|---------|--|--------------------------------------|------|---|-----------------|---|---|-------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | | MONTH | DAY | YEAR | 2b. HOUR 11:56 AM | |
| LINDA V PINKETT | | | | | | DEC. 12, 1984 | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| FEMALE | | NEGRO | | MONTH | DAY | YEAR | 22 | YRS. | MONTHS | DAYS | HOURS | MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| MARYLAND | | AMERICA | | | | | DORCHESTER, MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| CAMBRIDGE | | | DORCHESTER GENERAL | | | DISABLED | | | n/a | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13a. STATE | | | 13b. COUNTY | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE | |
| MARYLAND | | | DORCHESTER | | | HURLOCK | | | | | | P.O. 87 21643 | |
| 14. FATHER'S NAME | | | FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME | | | FIRST | MIDDLE | LAST | | |
| EARL | | | | | PINKETT | JANET (Jannard) | | | | | | FERRARE | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | | |
| NO | | | 512-84-4012 | | | Hilton Stanley, PO Box 87, Hurlock, Md. 21643 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| MASSIVE intra circulatory SICKLING of Red Blood Cells | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| (b) Sickle Cell Anemia | | | | | | | | | | | | | |
| { DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Infarction(s) | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | COUNTY | STATE | | |
| 22a. I certify that (1) (this hospital) attended the deceased from _____, 19_____, to 12-12, 1984, that (1) we last saw the deceased alive on 12-12, 1984, and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Mark Kelleher</i> | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 12-12-84 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Dec. 15, 1984 | | | 23c. NAME OF CEMETERY OR CREMATORIUM Reids Grove Cemetery | | | 23d. LOCATION CITY OR TOWN Reids Grove | | | COUNTY Dorchester, Md. | STATE |
| 24. FUNERAL DIRECTOR NAME Franklin Hawkins | | | ADDRESS Box 45, Federalsburg | | | 25a. DATE REC'D. BY REGISTRAR DEC 17 1984 | | | 25b. REGISTRAR'S SIGNATURE Julie Durden | | | | |



5
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | 3 3 6 0 2 | RECEIVED NO. 3 | | |
|--|--------|------------------------------------|-----------------------------------|--|--|-----------------------------------|---|--|--|--------|---------|--|---------------------|---------------------|-------|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH ESTI- MATED | | | | MONTH | DAY | YEAR | 2b. HOUR 8:00 AM | |
| | | | | Freeland | Eberman | Pritchett | <input type="checkbox"/> | | | | 12 | 14 | 1984 | | |
| 3. SEX | 4 RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6 AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | 2c. DATE PRONOUNCED DEAD | | | | MONTH | DAY | YEAR | 2d. HOUR 3:00 PM | | |
| M | Cau | 4 14 00 | 84 yrs. | | | <input type="checkbox"/> | | | | 12 | 14 | 1984 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | | | US | | | | | | | | Dorchester MD | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Bishops Head | | | | Dorchester General Hospital | | | | Retired | | | | Rural 21611 | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | |
| Md | | | | Dorchester | | | | Bishops Head | | | | Bishops Head | | | |
| 14. FATHER'S NAME FIRST | | | | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | | | | MIDDLE | LAST | | | | |
| David | | | | | Pritchett | Annie | | | | | Wingate | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | |
| | | | | 213-12-5633 | | | | Mrs. Maurice Robinson Item 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>liver disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to the immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>months</u> | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | | |
| | | | | | | | | <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET | | | | CITY OR TOWN | | COUNTY | STATE |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> , | | | | | | | | | | | | and in my opinion | | | |
| ACTUAL SIGNATURE <u>John Maurice Jr.</u> | | | | | | | | | | | | TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER | | | |
| EXAMINER'S NAME (TYPE OR PRINT) <u>JOHN MAURICE JR.</u> | | | | | | | | | | | | DATE SIGNED <u>12/14/84</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | | 23d. LOCATION CITY OR TOWN | | | |
| Burial | | | | 12/16/84 | | | | Pritchett Fam. Cemetery | | | | Bishops Head, Dor. Md. | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Thomas Funeral Home | | | | 700 Locust St. | | | | Md. DE-2 0184 | | | | <u>Julian Davidson Jr.</u> | | | |
| BP _____ | | | | | | | | | | | | | | | |
| DHMH - 17 (VR A15 ME (5)) | | | | | | | | | | | | | | | |
| 30M 7/73 | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon paper. Then please attach this to the burial permit. It should be detached for use as the burial permit. Please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 33603 | | | | | | |
|---|--|--|---|--|--|---|--|--|--|--|--|--|--|-----------------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 31 84 | | | | | | | | | 2b. HOUR 6A M | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST ANNA | | | MIDDLE MAE | | | LAST SAMPSON | | | | | | | | | |
| 3. SEX F | | | 4. RACE BLACK | | | 5. DATE OF BIRTH MONTH 4 DAY 29 YEAR 30 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Bel Air, Md. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dor. | | | MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Food processor | | | 12b. KIND OF BUSINESS OR INDUSTRY Food | | | | | | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Dorchester | | | 13c. CITY OR TOWN E. New Mkt. | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE Rt. 1, Box 9A | | | 21774 | | | |
| 14. FATHER'S NAME FIRST Benjamin F. | | | MIDDLE Tyler | | | LAST | | | 15. MOTHER'S MAIDEN NAME FIRST Dora E. Presbury | | | MIDDLE | | | LAST | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 212-28-0235 | | | 17. INFORMANT William E. Sampson, Rt. 1, Box 9A, | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Insufficiency DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis. DUE TO, OR AS A CONSEQUENCE OF (c) Alcoholism | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. MEDICAL CERTIFICATION | | | 20a. DATE OF OPERATION | | | | | | | | | 20b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20c. AUTOPSY? | | 20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) | | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from showing deceased alive on above, (I) (we) did not view the body after death. | | | 22b. DATE OF INJURY 12/22 1984 | | | | | | | | | 22c. DATE OF DEATH 10/31 1984 | | | 22d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 22e. SIGNATURE Arville | | | 22f. DEGREE | | | | | | | | | 22g. ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22h. DATE SIGNED 12/31 6A | | | |
| 22i. PHYSICIAN'S NAME (TYPE OR PRINT) Arville | | | 22j. ADDRESS 401 Maryland Ave EGE 21613 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE Jan. 5, 1985 | | | 23c. NAME OF CEMETERY OR CREMATORIAL E. New Market Cem. | | | 23d. LOCATION CITY OR TOWN E. New Market | | | 23e. COUNTIES Maryland | | | | | | |
| 24. FUNERAL DIRECTOR NAME Faymon-Fawkins - m.d. | | | 25a. ADDRESS Federalburg | | | | | | | | | 25b. DATE REC'D. BY REGISTRAR JAN 4 1985 | | | 25c. REGISTRAR'S SIGNATURE John Davidson Pendleton | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 33694 | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|--|--|---------------|--|
| 1 - FOR STATE REGISTRAR | | | 2a DATE OF DEATH MONTH DAY YEAR 12 / 6 / 84 | | | | | | | | | 2b. HOUR 3:00 AM | | | |
| I. DECEASED NAME (TYPE OR PRINT) | | | FIRST Edith | | | MIDDLE ADELE | | | LAST Shenton | | | | | | |
| 3. SEX female | | | 4. RACE white | | | 5. DATE OF BIRTH MONTH 08 DAY 05 YEAR 1906 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | | # UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Md. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY Canning | | | | | | |
| 13a. STATE Md. | | | 13b. COUNTY Dor. | | | 13c. CITY OR TOWN Cambridge | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 516 Goldsborough 21613 Ave. | | | |
| 14. FATHER'S NAME FIRST Charles | | | MIDDLE | | | LAST Robinson | | | 15. MOTHER'S MAIDEN NAME FIRST Sarah | | | MIDDLE | | LAST Sinclair | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 222-14-9019 | | | 17. INFORMANT Elsie Hubbard | | | ADDRESS Item # 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) SQUAMOUS CELL CARCINOMA RIGHT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. } DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED | | | (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____ | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 12/15/1984 to 12/6/1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We did) (did not) view the body after death. | | | | | | | | | | | | 22c. DATE SIGNED 12/6/84 | | | |
| 22b. SIGNATURE Michael A. Moskiewicz | | | DEGREE MD. | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOSKIEWICZ | | | 22e. ADDRESS 503 BYRN ST CAMBRIDGE MD. | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL ESPECIALLY | | | 23b. DATE 12/8/84 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park | | | 23d. LOCATION CITY OR TOWN Cambridge COUNTY Dor. STATE Md. | | | | | | |
| 24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE MD. | | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR 12/11/1984 | | | 25b. REGISTRAR'S SIGNATURE John Davidson-Pendleton | | | | | | |



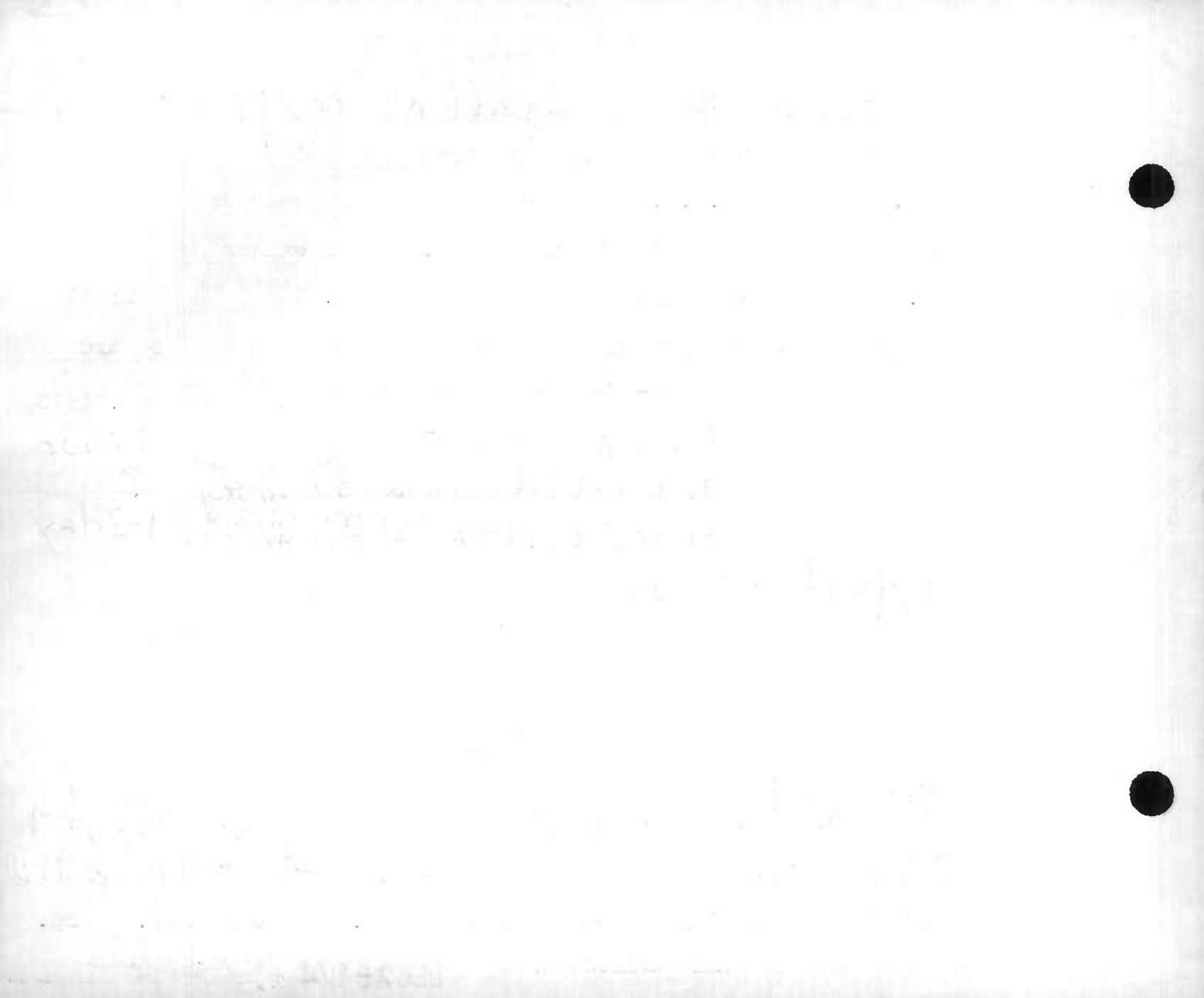
NO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be initialed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached from it as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 1B is marked or if item 1B shows any entry, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 33605 | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|--|--|---|--|
| 1 - FOR STATE REGISTRAR | | | 2a DATE OF DEATH 12/19/84 | | | | | | | | | 2b. HOUR 8:02 P.M. | | | |
| I. DECEASED NAME (TYPE OR PRINT) <i>Berthe Hellen Spedden</i> | | | MIDDLE <i>Hellen</i> | | | LAST <i>Spedden</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR 08 23 1900 | | | 2b. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 84 YRS. | | | |
| 3 SEX female | | | 4. RACE white | | | 5. DATE OF BIRTH MONTH DAY YEAR 08 23 1900 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | | | 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | | |
| 7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester | | | MD. | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| 13a. STATE Md. | | | 13b. COUNTY Dorchester | | | 13c. CITY OR TOWN Hudson | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE Rt. 3 21613 | | | |
| 14. FATHER'S NAME FIRST Robert | | | MIDDLE Preston | | | LAST Hubbard | | | 15. MOTHER'S MAIDEN NAME FIRST Sarah | | | MIDDLE Melinda | | LAST Seward | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 220-12-0313 | | | 17. INFORMANT Mildred Seward | | | ADDRESS Rt 3 Box 158 Cambridge Md. 21613 | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Myocardial Infarction { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) Probable Extension of Infarction { DUE TO, OR AS A CONSEQUENCE OF (c) Prior Subendocardial Myocardial Infarction | | | | | | | | | | | | ? | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Hypertension | | | | | | | | | | | | 1-2 day | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART II) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>P. Neal Reynolds MD</i> | | | 22c. DEGREE <i>MD</i> | | | ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> | | | 22d. DATE SIGNED <i>12/19/84</i> | | | | | | |
| 22e. PHYSICIAN'S NAME <i>H. Neal Reynolds</i> | | | 22f. ADDRESS <i>508 Bryn St. Cambridge Md.</i> | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | | 23b. DATE 12/22/84 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Seward Spedden Cem. | | | 23d. LOCATION CITY OR TOWN Hudson Dor. | | | 23e. COUNTY Md. | | | |
| 24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME | | | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR DEC 28 1984 | | 25b. REGISTRAR'S SIGNATURE <i>Linda K. Rendell</i> | |
| ADDRESS CAMBRIDGE MD | | | | | | | | | | | | | | | |



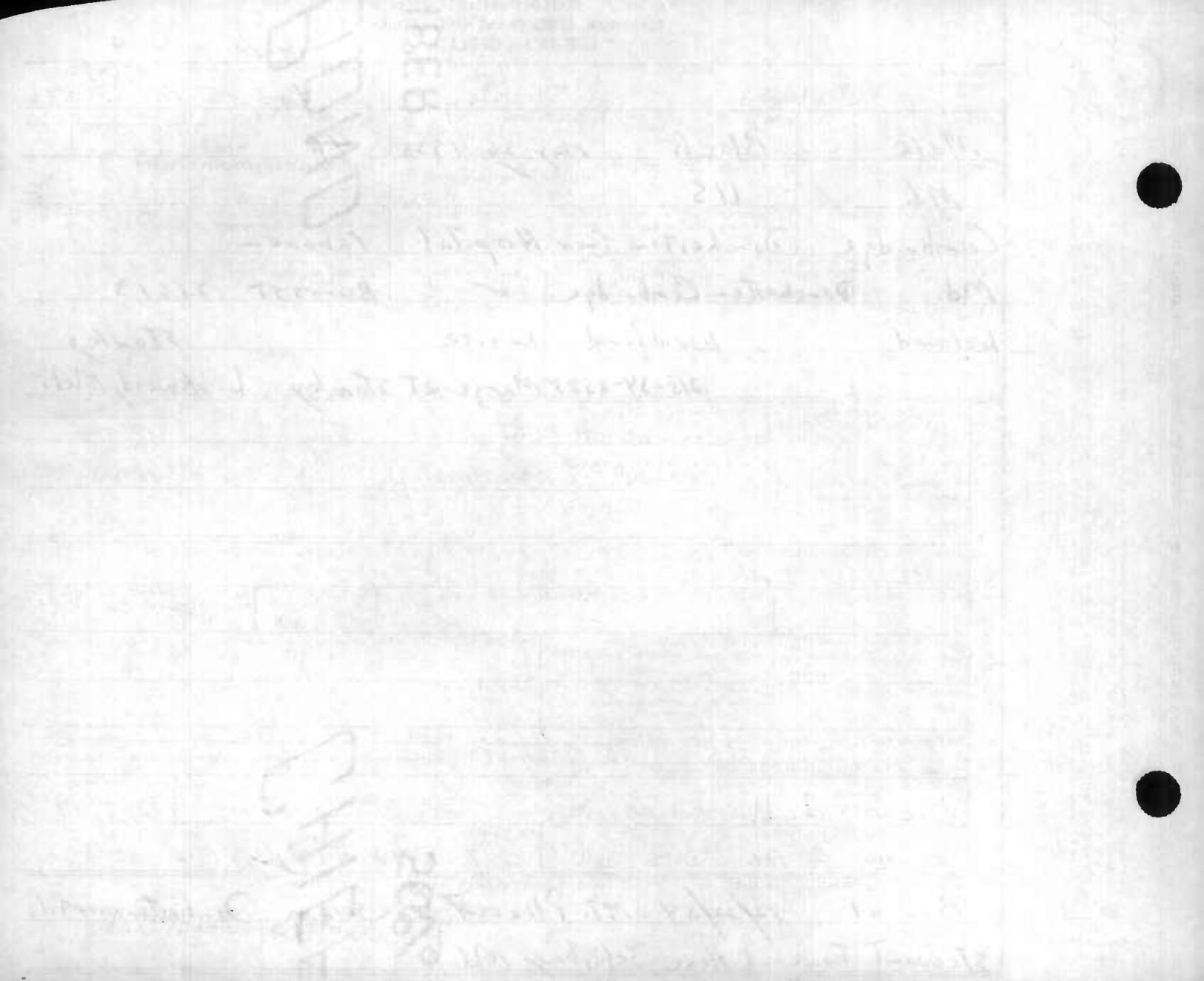
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 33606 | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|---|--|---|--|
| 1 - STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 20. DATE OF DEATH MONTH DAY YEAR | | | 2B. HOUR | | | |
| | | | JAMES | | | Stanley | | | Dec 15, 1984 | | | 2:45 A.M. | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| Male | | | Black | | | May 26 1938 | | | 46 YRS. | | | | | | |
| 7a. BIRTHPLACE COUNTRY | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Md. | | | U.S. | | | | | | Dorchester County MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Cambridge | | | Dorchester Gen Hosp. Tal | | | Labourer | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE | | | |
| Md. | | | Dorchester | | | Cambridge | | | | | | Burns St 21613 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | ADDRESS | | | | | | | | | |
| Belard | | | Wedford Louise Stanley | | | Margaret Stanley Lirkwood, Md. | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO. 17. INFORMANT | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| (IF YES, GIVE WAR OR DATES) 218-34-8588 | | | | | | | | | | | | | | 10 min | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE HYPERTENSION | | | | | | | | | | | | | | 46 yrs | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(b) | | | | | | | | | | | | | | | |
| RENAL FAILURE | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 19c. | | | 19d. | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/27/84 to 12/15/84, that (I) we lost saw the deceased alive on 12/15/84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) we did (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Michael A. Moskewicz MD | | | | | | | | | | | | | | 22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOSKEWICZ MD | | | | | | | | | | | | | | 22e. DATE SIGNED 12/15/84 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE 12/22/84 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Mt. Pleasant Cemetery | | | 23d. LOCATION CITY OR TOWN Seaford | | | 23e. COUNTY Dorchester | | | |
| 24. FUNERAL DIRECTOR NAME Stewart Funeral Home | | | ADDRESS Salisbury, Md. | | | 25a. DATE REC'D. BY REGISTRAR 12/17/84 | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 33607 | |
|--|--|---|---|---|--|---|--|--|---|---|-------|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR 12 17 84 | | | | | | | | | 2b. HOUR 2:35 AM | |
| 1. DECEASED NAME FIRST MIDDLE LAST Rhodessa H. Stewart | | | 2. DATE OF DEATH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | | |
| 3. SEX female | | | 4. RACE cau. | | | 5. DATE OF BIRTH MONTH DAY YEAR June 15, 1906 | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester | | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House Inc. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) crab-picker | | | 12b. KIND OF BUSINESS OR INDUSTRY shellfish | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Dorchester | | 13c. CITY OR TOWN Hooper's Isl. | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS rural | | MD. 21634 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WALTER TOLLEY | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE MOLLIE PARKER | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 212-16-7990 | | | 17. INFORMANT daughter Nancy Klopp, Fishing Creek, Md. | | | ADDRESS 21634 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) D. Mellitus | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Decubitus Ulcers | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 , to 19 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | 22c. DATE SIGNED 12-17-84 | |
| 22b. SIGNATURE | | | 22c. DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | 23b. DATE 12/19/84 | | 23c. NAME OF CEMETERY OR CREMATORIAL Hosier Mem. Church | | | 23d. LOCATION CITY OR TOWN Hooper's Isl. Dor. Md | | COUNTY | | STATE | | |
| 24. FUNERAL DIRECTOR Curran Funeral Home, Cambridge, Md. 21634 | | 25a. DATE REC'D. BY REGISTRAR DEC 20 1984 | | | 25b. REGISTRATION SIGNATURE | | | | | | | | |

3



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 33608 | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|--|--|--|---|--|--|--|--|--|-------------|--|--|-------|--|--|
| 1 - FOR STATE REGISTRAR | | | 2a. DATE OF DEATH 12/15/84 | | | MONTH DAY YEAR | | | 2b. HOUR 6:07 AM | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ZULA Jane TALL | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX Female | | | 4. RACE White | | | 5. DATE OF BIRTH MONTH 4/ DAY 30/ YEAR 1896 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS. | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE COUNTRY Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? US | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. MD. | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital | | | 12a. USUAL OCCUPATION 12b. KIND OF BUSINESS OR INDUSTRY Homemaker | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Dor. | | | 13c. CITY OR TOWN Cambridge | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 707 Hughlett Street 21613 | | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST Goldsborough | | | MIDDLE Fallin | | | LAST Jones | | | 15. MOTHER'S MAIDEN NAME FIRST Angie | | | MIDDLE Nora | | | LAST Jones | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 214-07-9590 | | | 17. INFORMANT Gorman R. Tall | | | ADDRESS 23 Glyndon Dr. Apt. 2 Reisterstown, Md. 21136 | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days. | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROSIS | | | | | | | | | | | | 7 days. | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY | | | STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/29/84 to 12/15/84, that (we) last saw the deceased alive on 12/15/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) did not view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Michael A. Moskiewicz MD | | | | | | | | | | | | 22c. DEGREE | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOSKEWICZ MD | | | | | | | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPEC#1) Burial | | | | | | | | | | | | 23b. DATE 12/8/84 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Green Lawn Cem | | | 23d. LOCATION CITY OR TOWN Cambridge Dor. Md. | | | 23e. COUNTY | | | STATE | | |
| 24. FUNERAL DIRECTOR NAME Thomas Funeral Home | | | | | | | | | | | | ADDRESS Cambridge, 700 Locust St., MD | | | 25a. DATE REC'D. BY REGISTRAR DEC 13 | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | |
| VRA 15, 4) | | | | | | | | | | | | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for us as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

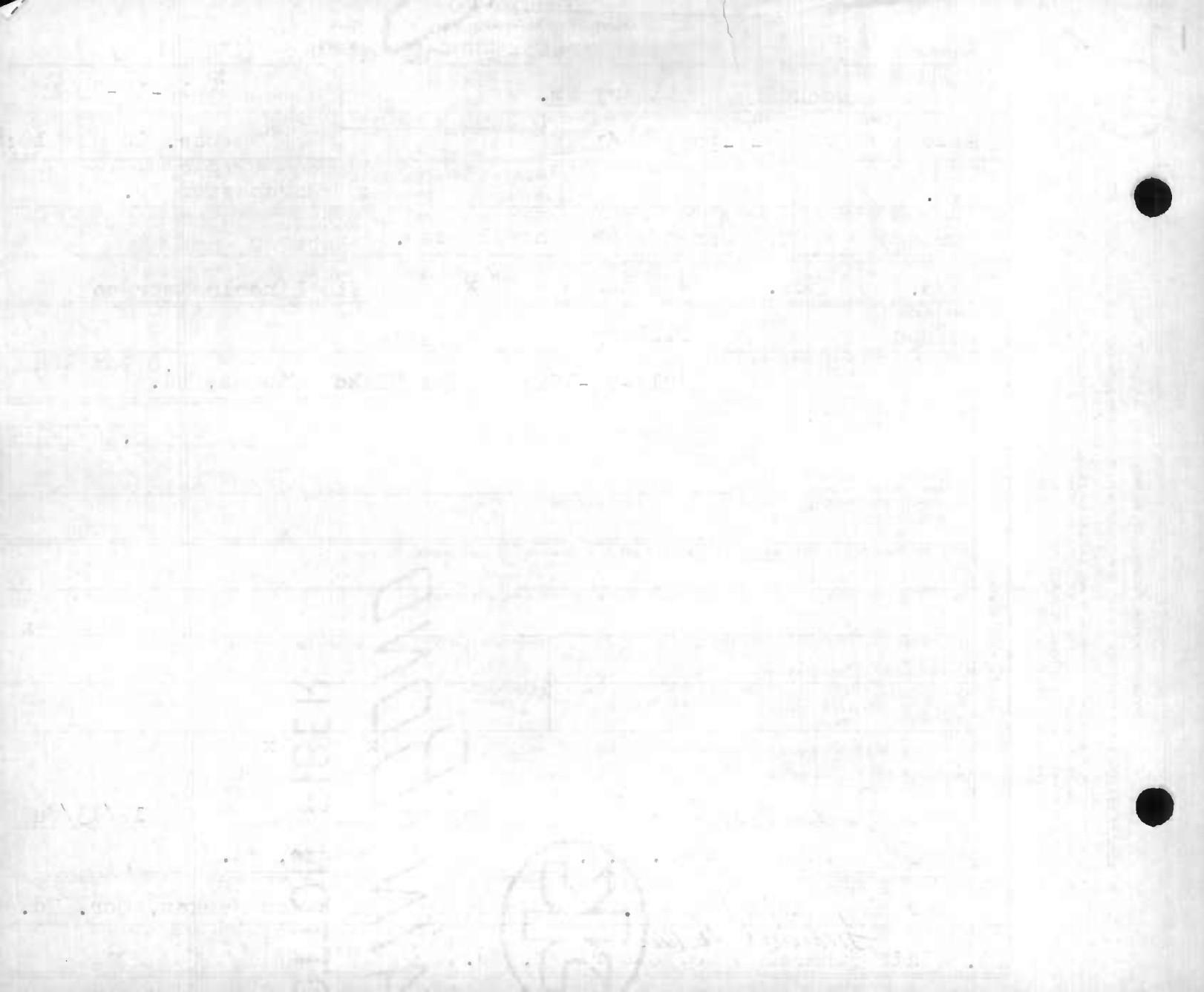
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 33609 | | | | |
|--|--|--|--|--|--|---|--|--|---|-------------------------------|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH 12-12-84 MONTH DAY YEAR | | | | | | | 2b. HOUR 3 ³⁰ P.M. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN. | | |
| Thomas, Milibud | | | m. | | | 07 10 09 | | | 75 YRS. | | | | | |
| 3. SEX F | | | 4. RACE CAU | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) operator-telephone co. | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 10. CITY OR TOWN OF DEATH Cambridge | | | 13a. STATE md. | | | 13c. CITY OR TOWN Dorchester Cambridge | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 211 Killarney Rd 21613 | | |
| 14. FATHER'S NAME FIRST Philip MIDDLE Alvah LAST Johnson | | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE LAST James | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 215-26-5052 | | | 17. INFORMANT Guy S. Thomas | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent metastatic | | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) adenocarcinoma of rectum | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year? | | |
| | | | | | | (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION June, 1984 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED above | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June, 19 84, to Dec 12, 19 84, that (I) (we) last saw the deceased alive on Jan 12, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE Lewis M. Burdette MD | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 12/12/84 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis M. Burdette | | | 22e. ADDRESS 4 Aurora St Cambridge, Md 21613 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | | 23b. DATE 12/14/84 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Md. Veterans Cem. | | | 23d. LOCATION CITY OR TOWN Beulah COUNTY Dor. STATE Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME | | | ADDRESS CAMBRIDGE MD. | | | 25a. DATE REC'D. BY REGISTRAR 12/12/84 | | | 25b. REGISTRAR'S SIGNATURE Julia Burdette | | | | | |
| DHMH - 16 50M 4/83 (VRA 15, 4) | | | | | | | | | | | | | | |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 4. RETAIN PAGE 5 FOR YOUR FILES.
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 33610 | | | | |
|--|--|---------|--|------------------------------------|-------------------|---|---|-------------------------------|--|-------------------------------|--|--|--|--|---|--|
| 1- STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE KNOWN OF ESTI- DEATH MATED | | | 2b. HOUR MONTH DAY YEAR 12-10-84 19 AM | | | | |
| Dock | | | Tillery Sr. | | | | | | <input checked="" type="checkbox"/> <input type="checkbox"/> | | | | | | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 7c. DATE PRONOUNCED DEAD | | 2d. HOUR MONTH DAY YEAR Dec. 10, 84 10:11 AM | | |
| Male | | Negro | | 7-1-1923 | | 61 | | | | | | Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | | | | |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7c. CITIZEN OF WHAT COUNTRY? | | | | | | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Va. | | | USA | | | | | | | | | Dorchester Co. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Cambridge | | | DOA Dorchester General Hosp. | | | Laborer | | | | | | | | | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | | |
| Md. | | | Dor. | | Cambridge | | | | 714 Lincoln Terrace | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | | | | |
| Joseph Tillery | | | Bessie ? | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | | P.O. Box 164 | | | | |
| No | | | 213-05-1523 | | | Gladys Blake Vienna, Md. | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Mins | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | | | | | |
| | | | | | | | | | <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | 21f. LOCATION STREET | | | CITY OR TOWN | | | COUNTY STATE | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>John Mace Jr.</i> | | | TITLE (SPECIFY) M.D. Deputy | | | MEDICAL EXAMINER | | | DATE SIGNED 12/13/84 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | John Mace Jr. M.D. | | | ADDRESS Cambridge, Md. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE Burial 12/18/84 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Cemetery | | | 23d. LOCATION CITY OR TOWN East New Market, Dor. Md. | | | COUNTY STATE | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| St. Clair Funeral Home, Cambridge, Md. | | | | | | | | | DEC 17 1984 | | | <i>Julia Saunders</i> | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retorted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or asked.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 8 4 | | | | | | | | | | | | REV. NO. 3 6 1 1 | |
|--|--|--|---|--------|---|---|--|---|---|----------------|--|--|--|
| 1 - STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | | | | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST | MIDDLE | LAST | | | 12 - 7 - 84 | | | 9 A.M. | | |
| Carroll | | | E. | | Waters Jr. | | | | | | | | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR | | |
| Male | | | Negro | | MONTH DAY | | | 53 | | | IF UNDER 24 HRS | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MONTHS DAYS HOURS MIN. | | |
| Md. | | | USA | | | | | Dorchester | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| Cambridge | | | Dorchester General Hosp. | | | | | | | | | Teacher | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE | | |
| Md. | | | Dor. | | Cambridge | | | | | | 710 Pine St. 21613 | | |
| 14. FATHER'S NAME | | | FIRST | MIDDLE | LAST | | | 15. MOTHER'S MAIDEN NAME | | | LAST | | |
| Carroll | | | E. | | Waters Sr. | | | Elizabeth | | | Peach | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| Yes USAF | | | 217-28-3116 | | (Cousin) | | | Elsie Smith 710 Pine St. Camb., Md. | | | 21613 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Cardiopathy</u> (b) <u>Recent myocardial infarction</u> (c) <u>Chronic Ventricular Arrhythmia</u> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Personality Disorder</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from <u>March 12-1</u> , 19 <u>84</u> , to <u>12-7</u> , 19 <u>84</u> , that (we) last saw the deceased alive on <u>March 12-1</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) did (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>L.H. Boardley</u> | | | 22c. DEGREE <u>MD</u> | | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22e. DATE SIGNED | | | | |
| 22f. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22g. ADDRESS | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIAL | | | 23d. LOCATION CITY OR TOWN | | 23e. COUNTY | | | |
| Burial | | | 12/12/84 | | Md. Vet. Cemetery | | | Beulah | | Dor. Md. 21613 | | | |
| 24. FUNERAL DIRECTOR NAME <u>L.H. Boardley Funeral Home</u> | | | ADDRESS <u>Camb., Md.</u> | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE <u>DEC 13 1984 L. H. Boardley</u> | | | | |

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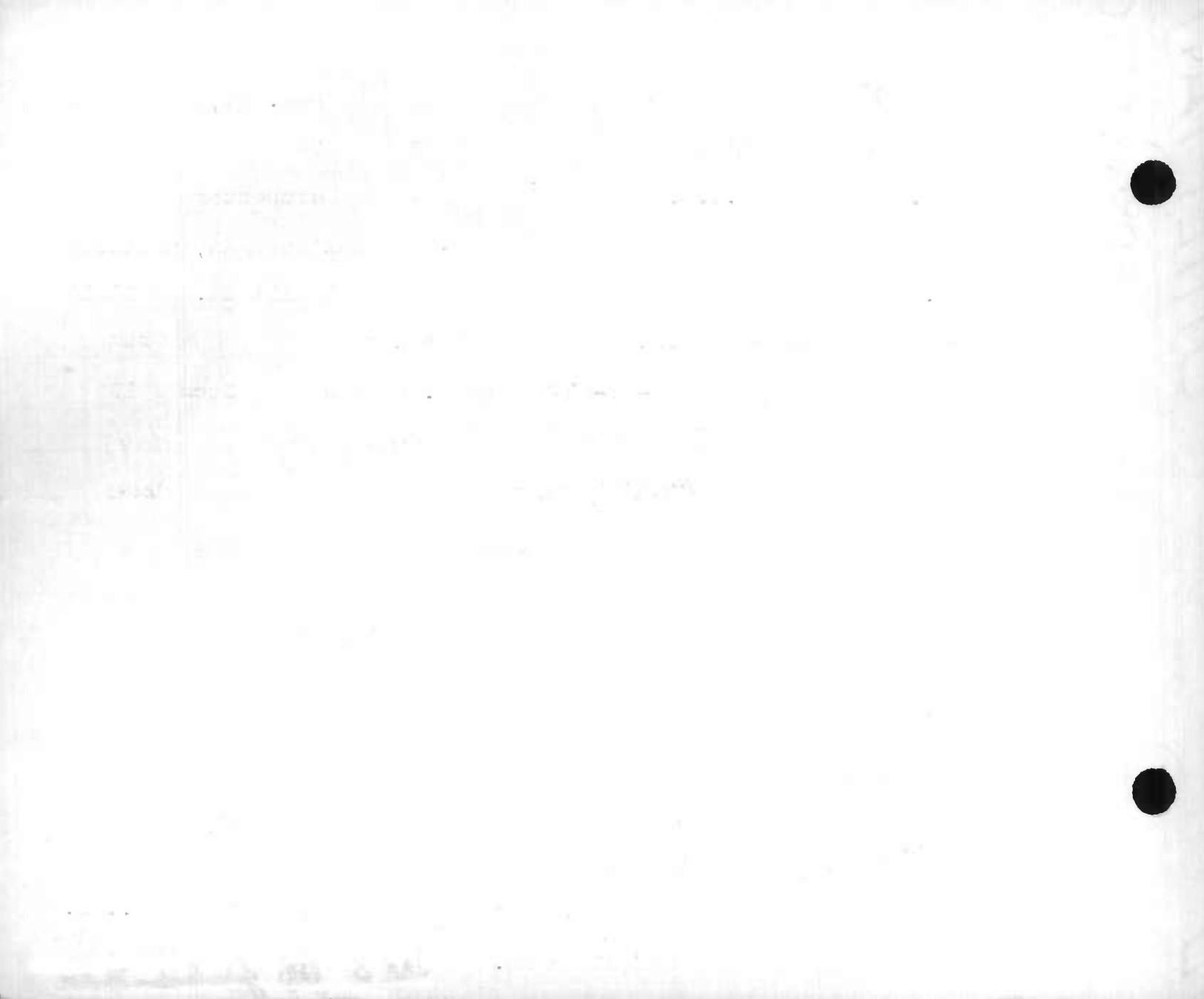
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | | REG. NO. 33612 | |
|---|--|--|--|--|--|--|--|--|--|--|--|--------------------------------|--|
| 1 - FOR STATE REGISTRAR | | | 2a DATE OF DEATH MONTH DAY YEAR Dec. 27, 1984 | | | | | | | | | 2b. HOUR 9:30P | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST Harvey T. | | | MIDDLE Wilson | | | LAST | | | | |
| 3. SEX male | | | 4. RACE white | | | 5. DATE OF BIRTH 03 22 1905 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 79 | | | IF UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE COUNTRY Md. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester | | | IF UNDER 24 HRS HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH Cambridge | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hosp. | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Businessman, | | | 12b. KIND OF BUSINESS OR INDUSTRY retired | | | | |
| 13a. STATE Md. | | | 13b. COUNTY Dorchester | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE 101 Mill St. 21613 | | | | |
| 14. FATHER'S NAME FIRST George MIDDLE Hicks LAST Wilson | | | 15. MOTHER'S MAIDEN NAME FIRST Florence MIDDLE Orem LAST | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 214-07-8379 | | | 17. INFORMANT Lena R. Wilson | | | ADDRESS Item # 13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxico-Metabolic Encephalopathy | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | (b) Hypoglycemia | | | | | | hours | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Christine L. Galanos | | | 22c. DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | 22d. DATE SIGNED | | | | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) Christine L. Galanos | | | 22f. ADDRESS | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | | 23b. DATE 12/30/84 | | | 23c. NAME OF CEMETERY OR CREMATORIAL Dor. Memorial Park | | | 23d. LOCATION CAMBRIDGE COR. DOR. MD. STATE | | | | |
| 24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE MD. | | | 25a. DATE REC'D. BY REGISTRAR JAN 3 1985 | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, file medical examiner's report.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 33613 | | | | |
|--|--|---|-------------------|---|---|----------------------------------|---|--|--|--|------------|--|-------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | | | | |
| WILLIAM Costen WRIGHT | | | | | | 12/5/84 | | | 1:05 PM | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | | |
| Male | | Caucasian | | 10 11 26 | | | 58 YRS | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | MD. | | | | |
| Maryland | | USA | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | Dorchester | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | |
| Cambridge | | Dorchester General Hospital | | | | | | | | Bridge Operator | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE | | | | |
| Maryland | | Talbot | | Trappe | | | | | | Rt. 1 Box 66 A/21673 | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | | | | |
| William Walter Wright | | Vesta Costen | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | | | | | | |
| YES Korean | | 213-22-9051 | | Margaret Wright | | | see 13e. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour. | | | | |
| DOUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION | | | | | | | | | | | | | | |
| DOUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROSIS | | | | | | | | | | 4 YEARS | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 19a. | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | 21d. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 12/5 1984, to 12/5 1984, that (1) (we) last saw the deceased alive on above (1) we (did) did not view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE MICHAEL A. Moskiewicz MD | | | | | | | | | | | | | | |
| 22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | | | | | | | | | |
| 22d. DATE SIGNED 12/5/84 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | 22f. ADDRESS | | | | | | | | | |
| MICHAEL A. Moskiewicz MD | | 503 BYRN ST CAMBRIDGE MD 21613 | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORIUM | | | 23d. LOCATION CITY OR TOWN | | 23e. COUNTY | | 23f. STATE | | | |
| Burial | | 12-7-84 | | Woodlawn Memorial | | | Easton | | Talbot | | Md. | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Newnam Funeral Home | | Easton, Md. | | | DEC 7 1984 | | June K. Kinsella | | | | | | | |

